Family and Social Services Administration
Office of Medicaid Policy and Planning

Indiana MITA Assessment Project

4TG WBS Reference 3.2 (OMPP Deliverable 2.4.3)

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FOURTHOUGHTGROUP

Revision History

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2.0	07.03.08	Miller	Changes based on Crowe Revisions
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1 Executive Summary

The Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) contracted with FourThought Group (4TG) to conduct a Medicaid Information Technology Architecture State Assessment of the Indiana Medicaid Enterprise. This deliverable, the Indiana Medicaid Enterprise MITA Current Capabilities Assessment, represents the findings of the assessment of the current or "As Is" capability maturity level of the core business and technical capabilities of the Indiana Medicaid Enterprise.

The overall average capability maturity level of the Indiana Medicaid Enterprise for all MITA business process is at a ***Level 1*** or lowest level of capability maturity. Capability maturity Level 1 means the "Agency focuses on meeting compliance thresholds for State and Federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment claims for appropriate services."

The MITA Assessment is conducted by aligning the core Indiana Medicaid business areas and processes with the MITA Business Model to establish an Assessment Standard. The MITA Business Model defines 8 Business Areas core to the administration of the Medicaid Enterprise, and is further defined by 78 Business Processes detailing practices that are essential to the operation of the Medicaid health plan.

To assess the capability maturity of each of the aligned MITA business processes in the Assessment Standard, 4TG gathered and analyzed information from a wide range of sources to assess characteristics of timeliness, access, efficiency, effectiveness, accuracy, quality and value for

each capability at the five progressive levels of capability maturity levels. The capability maturity levels range from 1 to 5 -- 1 being the lowest and 5 being the highest.

The Assessment findings were developed through:

- an extensive survey of Business Leads to gather their input and resource documentation,
- an exhaustive analysis for more than 9,000 pages of documentation, follow up questions and survey responses,
- a survey and Focus Group of Provider Association representatives,
- an analysis of characteristics and scoring of capabilities utilizing the 4TG Maturity Assessment Tracking Toolset, and
- More than 40 hours of interactive validation assessment sessions with Business Leads and Subject Matter Experts from the public and private sectors of the Medicaid Enterprise.

The deliverable details the purpose, process and findings of the Current Capabilities phase of the MITA Assessment. It provides the baseline against which the Target or "To Be" Assessment as well as future progress towards the Medicaid Enterprise Envisioned Future will be assessed.

2 Purpose

The purpose of this document is to present an assessment of the current capability maturity of the Indiana Medicaid Enterprise business area processes. This section provides an overview of the project background and the approach for and methodology of this phase of the assessment.

The Current Capability Assessment provides the baseline for assessment of Target Capabilities and for the measurement of progress of the Medicaid Enterprise towards its Envisioned Future.

2.1 Background

OMPP engaged 4TG to provide "a thorough and complete MITA Assessment for OMPP adhering strictly to the MITA Standards and Framework 2.0",[1] covering the Indiana Medicaid Enterprise, which OMPP defines as "all Medicaid business processes administered or purchased by OMPP."

The goal of the Indiana MITA Assessment Project is to define a process improvement roadmap to achieve the Indiana Medicaid Health Care long term vision by:

- Optimizing Medicaid's expanded use of technology to achieve its goals and objectives;
- Satisfying the Center for Medicare and Medicaid's (CMS) Advance Planning Document requirement to receive Federal approval for enhanced Federal funding for systems design, development & implementation;
- Facilitating statewide health information exchange; and
- Improving organizational alignment to achieve our long term vision in meeting the needs of Hoosiers.

Indiana FSSA OMPP contracted with 4TG to facilitate, assist, and conduct a MITA Assessment Project to develop the following major deliverables:

[1] State of Indiana Request for Services 7-94, May 29, 2007.

1. Indiana Medicaid Health Care Envisioned Future, which is the vision for the future Medicaid Enterprise 2018,
2. Indiana Medicaid Assessment Standard, which is a mapping of Indiana's Medicaid Business Process Model to the MITA Business Process Model to establish the standard to be deployed for the MITA Assessment,
3. Current Capabilities Assessment, which is this document that assesses the current ("As-Is") business capabilities of the Medicaid Enterprise,
4. Target Capabilities assessment, which includes the analysis of the future vision and goals of the Medicaid Enterprise and the assessment of the capability maturity of these target ("To-Be") business capabilities,
5. Transition and Implementation Plan, which includes a identification of the high-level transition strategy and priority projects to close the gap between the current and target capabilities to achieve the envisioned future for the Medicaid Enterprise,
6. Information Repository to track and store project and assessment documentation,
7. Project Management, including project plan, schedule and deliverable definitions, and
8. Provider Association Focus Group Deliverable, which describes the input and feedback of a representative sample of Indiana providers regarding the Medicaid Enterprise Envisioned Future, the performance of its current capabilities and their recommendation for short and long term priorities to achieve the future vision.

This Current Capabilities document represents one of the key deliverables of this project, and reflects the current or "As Is" state of capability maturity of the Indiana Medicaid Enterprise.

The remainder of this section provides a high-level overview of the MITA Business Architecture focusing on the MITA Business Model, including Business Areas and Processes, as well as the Capability Maturity Model, including capabilities, characteristics and measures.

2.2 MITA Overview

The Medicaid Information Technology Architecture (MITA) is a roadmap and toolkit for States to transform their Medicaid Management Information System (MMIS) into an enterprise-wide, beneficiary-centric system. MITA will enable State Medicaid agencies to align their information technology (IT) opportunities with their evolving business needs. It also addresses long-standing issues of interoperability, adaptability, and data sharing, including clinical data, across organizational boundaries by creating models based on nationally accepted technical standards. Perhaps most significantly, MITA allows State Medicaid Programs to actively participate in the DHHS Secretary's vision of a transparent health care market that utilizes electronic health records (EHR's), ePrescribing and personal health records (PHR's).[2]

The MITA is an initiative of the CMS Center for Medicaid & State Operations (CMSO). MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program.

MITA fosters integrated business and technology transformation of the State Medicaid enterprise by providing a new process for States plan to technology investments, and design, develop, enhance or install Medicaid information system. MITA provides a business-driven architectural framework, process model, and planning guidelines for States to define their strategic business goals and objectives, align their business processes with the MITA national

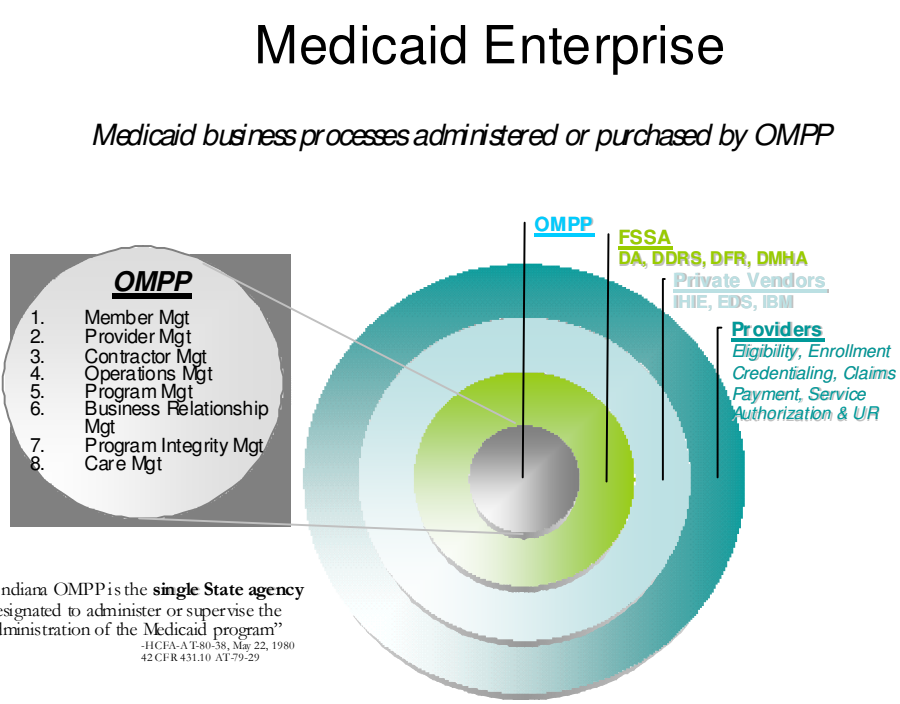
[2] Richard H. Friedman, Medicaid Information Technology Architecture: An Overview, Health Care Financing Review, Winter 2006-2007, Volume 28, Number 2 http://www.nasmd.org/issues/docs/Friedman.pdf

model and assess their current capabilities as a baseline for measuring progress towards their Envisioned Future.

MITA is designed to support and enable integrated business and technology transformation of the Medicaid Enterprise. The MITA Business Architecture is based on a Capability Maturity Model (CMM); the best known as which is the Software Engineering Institute's (SEI) Capability Maturity Model® Integration (CMMI). CMM and CMMI is a "process improvement approach that provides organizations with essential elements of effective processes" and "helps integrate traditionally separate organizational functions, set process improvement goals and priorities, provides guidance for quality processes, and a point of reference for appraising current processes."[3]

This Current Capability ("As Is") Assessment provides the foundation for integrated transformation through a process improvement approach using the following tools, techniques and standardization approach.

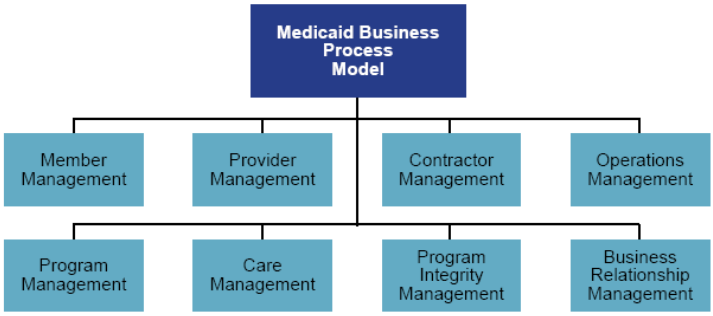
- *MITA Assessment Standard* is a mapping of Indiana Medicaid Enterprise business processes to the MITA 2.0 Business Process Model,
- *Medicaid Enterprise*, according to CMS, involves three spheres of influence: (1) State Medicaid operations for which Federal matching



[3] Cargnie Mellon, Software

funds apply; (2) interfaces and bridges between the State Medicaid agency and State and Federal Medicaid stakeholders and (3) the nationwide health information community, including the HHS Office of the National Coordinator for Health Information Technology, standards development organizations and other Federal agencies. Indiana has defined the Medicaid Enterprise to include all business processes that are administered or purchased by OMPP.

- *MITA Business Process Model* (BPM) details the eight Business Areas that are common to Medicaid health programs and plans across the country. The areas are decomposed into 78 Business Processes. The definitions of these processes are the foundation for the business capabilities and the assessment framework.



- *MITA Maturity Matrix* (MMM) – capabilities, characteristics and measures to assess the maturity level for all capabilities that comprise the MITA Business Process across the Medicaid Enterprise. The MMM was developed based on industry and government models. The MMM defines the boundaries for each level of Medicaid improvement or transformation and provides a structure for definition of business capabilities and measurements.

MITA Capability Maturity Model				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Focus on compliance thresholds for State and Federal regulations, accurate	Cost management focus to improve quality of and access to care within	Coordination and collaboration with other entities to adopt national	Through widespread and secure access to clinical data, focus on improving health	Optimize program management and interoperability, automate routine

enrollment of eligible persons and timely and accurate payment of claims for appropriate services.	structures designed to manage costs (e.g. managed care, catastrophic care management and disease management).	standards, develop and reuse business processes that improve cost effectiveness of health care service delivery, and promote intrastate data exchange.	care outcomes, empower members, providers and stakeholders, and measure quantity for program improvement.	operations, plan and evaluate on basis of national/international quality standards.

- *Business Capability Model* (BCM) describes the enterprise's capability to reliably and repeatedly execute a business process at a certain level of maturity. The model configured in matrix that defines the progressively mature business process across five levels. A capability reflects the competence of an individual, organization or system to perform a function or process. At each level the process is defined, and assessed based on the findings across each of the following measureable characteristics or qualities:
    - Timeliness of business process
    - Data accuracy and accessibility
    - Ease of performance/efficiency
    - Cost effectiveness
    - Quality of process results and
    - Utility or Value to stakeholders.

The Current Capability Assessment uses the Indiana MITA Assessment Standard as the framework to assess business capabilities and measure the capability maturity of the Indiana Medicaid Enterprise, and thereby construct a baseline or point of reference for assessing the progress of the Enterprise towards its Envisioned Future.

2.3 Approach

The Current Capabilities Assessment was conducted through the use of surveys with Medicaid Enterprise Business Process Leads and Provider Association Focus Group participants, extensive information and documentation review and analysis, comprehensive validation sessions with Business Leads and Subject Matter Experts from the public (OMPP, ISDH, FSSA divisions: DMHA, DDRS, DA, DFS) and private sectors of the Medicaid Enterprise to review and validate the detailed draft capability findings. See Appendix A for the list of participants involved in the Current Capabilities Assessment. In addition, 4TG also conducted a consultation and dialogue with the Chief Information Officer and Business Champion on nationwide Health Information Technology trends and the impact on Indiana's IT plans.

2.3.1 Survey

To make the most effective use of staff time and maximize documentation and information for detailed analysis, 4TG developed an electronic survey to request documentation about each of the Indiana Medicaid Enterprise MITA business processes, and future plans. These surveys were submitted to Business Leads electronically and additional technical assistance was provided to Business Leads and Subject Matter Experts from throughout the public and private sectors of the Medicaid Enterprise. Business Leads were requested to complete the survey and post relevant documentation to the MITA Project SharePoint site for shared access and analysis.

2.3.2 Documentation Review

The 4TG team reviewed, catalogued and analyzed all documentation and information provided through survey responses, electronic documentation loaded onto the MITA Project SharePoint site, and e-mails and telephone

calls to ensure complete and thorough understanding of the business process capabilities.

In addition, 4TG identified key questions and outstanding issues for follow up with Business Leads, Subject Matter Experts and business units to confirm proper interpretation and analysis. As a part of this review, Business Analysts identified all documents and information relating to a business process, and analyzed capability characteristics. In addition to documentation identified by Business Leads and their team members, 4TG Business Analysts also conducted extensive web research, and reviewed assessment and report findings by other consulting firms working with the Medicaid Enterprise. This information was recorded in spreadsheets to aid in the scoring process and detailed reports.

2.3.3 Capability Maturity Assessment Scoring

To conduct the MITA Current Capability Assessment Scoring, 4TG utilized the Maturity Assessment Tracking Toolset (MATT) which is a web-enabled application that enables a valid and reliable Assessment Standard and framework. The 4TG methodology and application has proven successful in multiple states across the country.

4TG Business Analysts used MATT to track, measure, and assess information compiled from the surveys and other sources to document the characteristics of each of the MITA Business process capabilities. Through this analysis each characteristics was analyzed, capabilities were assessed and the capability maturity scoring was compiled.

2.3.4 Validation Sessions

Upon completion of the initial analysis and scoring, 4TG conducted a series of stakeholder validation sessions with the Business Leads and key subject matter experts (vendors, FSSA division resources). The purpose of those sessions was to validate the Capability Maturity Assessment Scoring as well as 4TG's understanding of the information obtained from the survey. 4TG then revised the preliminary results of the Current Capability Assessment and incorporated changes from these validation sessions into the As-Is Assessment reports that are incorporated in this document.

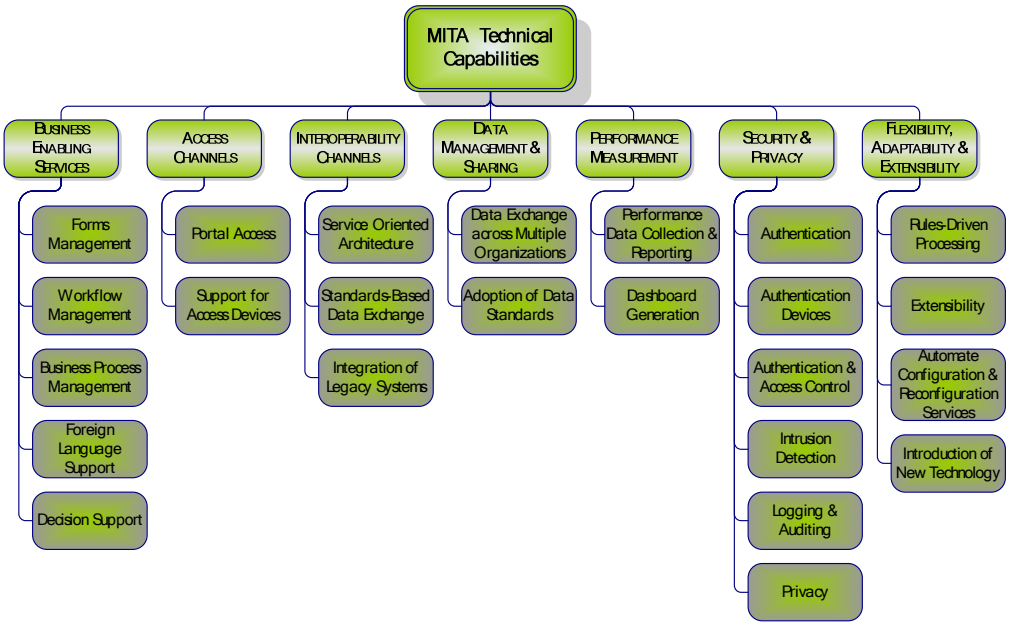
The scope of the validation sessions included all 78 business process in the MITA 2.0 model. Some of those processes are currently defined as "To Be Determined". For these gaps in the MITA model, 4TG has created an assessment model to address the gaps based on their industry experience and Medicaid knowledge. That enhanced model was used during the validation sessions, and can be utilized for State Self-Assessments.

2.3.5 Technical Capability Analysis

The Indiana RFS for MITA SSA Services required a technical capability assessment using the Technical Capability Matrix (TCM) contained in the MITA 2.0 framework. The MITA 2.0 Framework, related to the TCM is the least developed portion of the MITA framework and currently cannot be realistically used to assess an entities technical capability maturity. In an effort to meet the spirit of the RFS related to current capability assessment of the Indiana Medicaid Enterprise, 4TG reviewed existing documentation on the current technology in place in Indiana and met with the FSSA CIO to discuss current industry trends and future plans for further development of the MITA Technical Capability Matrix. This section of the document will discuss the findings of our review of documentation and interaction with

FSSA Chief Information Officer, Ingram Liljestrand and MITA SSA Business Champion Randy Miller related to the current technical capability maturity present currently in Indiana.

The diagram below represents the current MITA 2.0 Technical Capability Matrix that was used as a part of this assessment.



Similar to the Business Capability Maturity Assessment, 4TG conducted a review of technology capability documentation, reviews and reports to develop an assessment of the current Technical Capabilities for the Medicaid Enterprise.

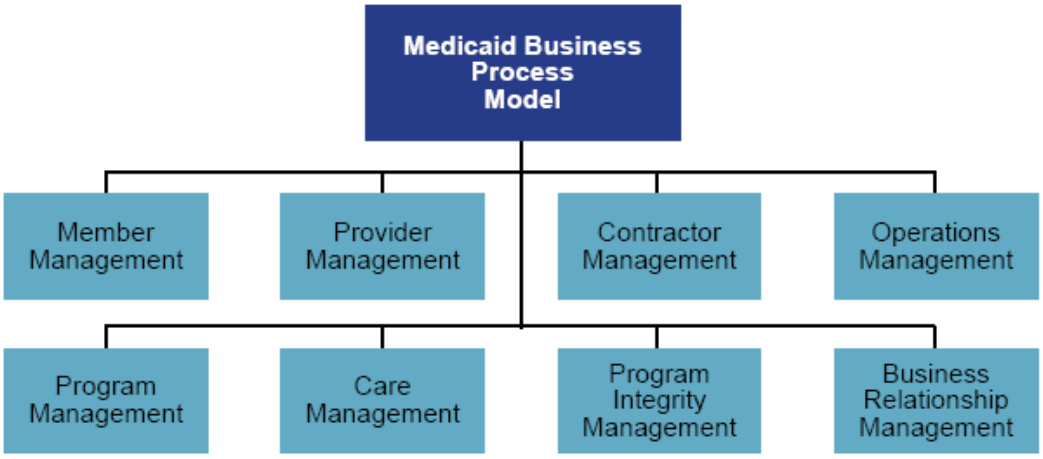
Based on the information gathering and analysis methodology described above, 4TG developed a set of findings to inform the Indiana OMPP of the current capability maturity level of the Medicaid Enterprise. This assessment represents a baseline from which progress toward the Target Capabilities may be assessed. The current capability maturity level is documented in the rest of this deliverable, and the Indiana As-Is Assessment Detail Report is presented in Appendices.

3 Business Capability Findings

The Indiana Medicaid Enterprise MITA Assessment Current Capabilities Findings are contained in the part of the deliverable. This opening section list the overall maturity level for the Indiana Enterprise by Medicaid Business Areas.

Following this section, the results of each Business Area Current Capability Assessment are detailed in the following manner:

- **Business Area and Business Process Description** – *includes a graphic, summary description and aggregated Capability Maturity Level for all capability characteristics for each Business Process in the Business Area*,
- **Current Capability Maturity Assessment Results** – *includes a matrix listing all Business Processes, Business Process Capabilities, Description and aggregated Capability Maturity Level,*
- **Capability Maturity Findings** – *provides an overview of findings about the capabilities in the Business Area, additional details of findings at the Business Process level and any comments or concerns raised by the Provider Association Focus Group and*
- **Strengths and Weaknesses of Current Business Processes** – *provides high level, point-in-time observations about current business processes.*


Medicaid Business Process Model
Member Management
Provider Management
Contractor Management
Operations Management
Program Management
Care Management
Program Integrity Management
Business Relationship Management

Indiana MITA Medicaid Enterprise Capability Maturity Level by Business Area

Business Areas	*Description*	*Maturity Level*
Member Management	Focuses on communications between the Medicaid agency and the prospective or enrolled beneficiary and actions that the agency takes on behalf of the beneficiary.	1
Provider Management	Focuses on recruiting potential providers, supporting the needs of the population, maintaining information on the provider, and communicating with the provider community.	1
Contractor Management	Includes managed care contracts and other essential outsourced contracts.	1
Operations Management	Focuses on operations that support the payment of providers, managed care organizations, other agencies, insurers, and Medicare premiums and support the receipt of payments from other insurers, providers, and member premiums.	1
Program Management	Includes strategic planning, policy making, monitoring, and oversight activities of the agency. These activities depend heavily on access to timely and accurate data and the use of analytical tools.	1
Care Management	Focuses on the needs of the individual member information, including plan of treatment, targeted outcomes and health status, as well as other business processes with a common purpose (e.g., identify clients with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes).	1
Program Integrity Management	Incorporates those business activities that focus on program compliance (e.g., auditing and tracking medical necessity and appropriateness of care and quality of care, fraud and abuse, erroneous payments, and administrative abuses).	1
Business Relationship Management	Focuses on collaboration between in-State agencies and inter-State and Federal agencies, and includes the interoperability standards between the agency and its partners.	1

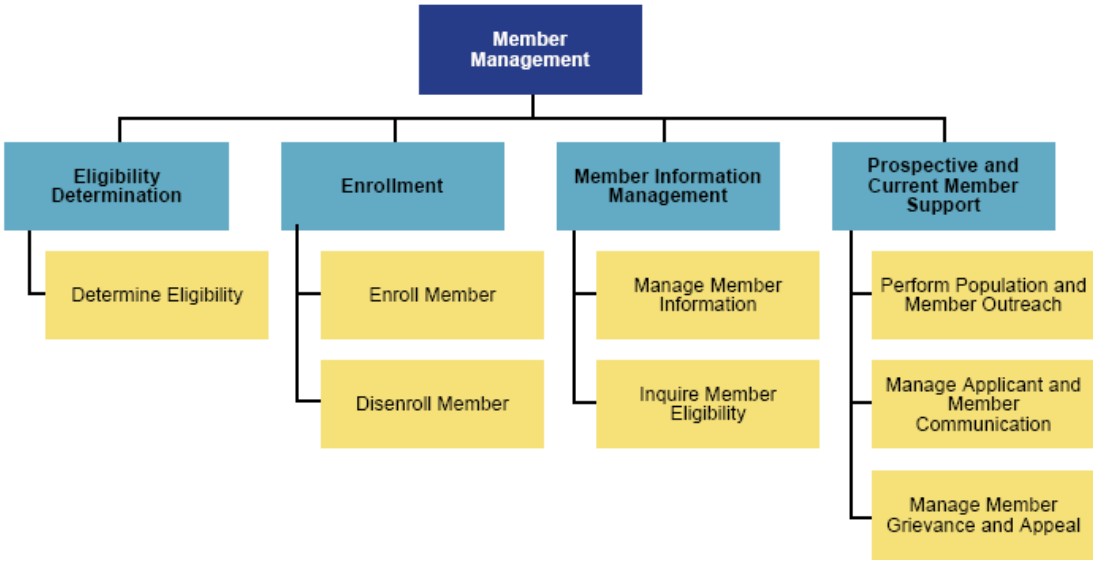
Based on the findings of the detailed assessment the overall Capability Maturity Level of the Indiana Medicaid Enterprise is currently at a Level 1. This is the lowest capability maturity level and is associated with an enterprise that is focused on meeting:

- Compliance thresholds with State and Federal regulations,
- Timely and accurate member eligibility and member and provider enrollment, and
- Timely and accurate payment for appropriate services.

As the MITA Maturity Model is progressive, mastery of these core capabilities is essential and necessary prior to achievement of higher order capability maturity or functionality.

3.1 Member Management

3.1.1 Business Area and Business Process Description



The Member Management business area is a collection of business processes involved in communications between the Medicaid agency and the prospective or enrolled beneficiary and actions that the agency takes on behalf of the beneficiary. These processes share a common set of beneficiary-related data. The goal for this business area is to improve healthcare outcomes and raise the level of consumer satisfaction.

This business area is transformed in the future from agency staff performing eligibility and enrollment functions to more patient self-directed decision making.

Member Management business processes consolidate many eligibility and enrollment functions into a single, generic business process. Determine Eligibility, for example, covers Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), State Children's Health Insurance Program (SCHIP), and other programs. Enroll Member includes enrollment in managed care programs, carved-

out benefit plans (e.g., pharmacy, dental, or mental health services), waiver service programs, and gatekeeper or lock-in programs.

3.1.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Eligibility Determination – *Determine Eligibility*	Receives eligibility application data set from the Receive Inbound Transaction process; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID, establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications. Most States accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member Registry. This may require conversion of the data. However, this process will be used by the other states which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for state-only programs.	1
Enrollment – *Disenroll Member*	Responsible for managing the termination of a member's enrollment in a program, including: ▪ Processing of eligibility terminations and requests for disenrollment (submitted by the member, a program provider or contractor) ▪ Disenrollment based on member's death; failure to meet enrollment criteria, such as	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	a change in health or financial status, or change of residency outside of service area (requested by another Business Area, e.g., Prepare Member Payment Invoice process for continued failure to pay premiums or Program Integrity for fraud and abuse) ▪ Mass Disenrollment due to termination of program provider or contractor ▪ Validation that the termination meets state rules ▪ Requesting that the Manage Member Information process load new and changed disenrollment information ▪ Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including. The Capitation and Premium and Member Payment Management Areas business processes about changed Member Registry information for payment preparation--The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights. Enrollment brokers may perform some of the steps in this process	
Enrollment – *Enroll Member*	Receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP, waiver), loads the enrollment outcome data into the Member and Contractor Registries, and produces notifications to the member and the contractor.	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Either the Agency or enrollment brokers may perform some or all of the steps in this process.	
Member Information Management – *Inquire Member Eligibility*	Receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction. This transaction indicates whether the member is eligible for Medicaid health benefit plan coverage, per HIPAA, and may include more detailed information about the Medicaid programs, benefits and services, and providers from which the member may receive covered services.	1
Member Information Management – *Manage Member Information*	Responsible for managing all operational aspects of the Member Registry -- the source of comprehensive information on applicants and members, and their interactions with the Medicaid Enterprise. The Member Registry is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member's covered services, and all communications, e.g.,	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	outreach and EOBs, and interactions related to any grievance/appeal. The Member Registry may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member Registry to add, delete, or change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity. The Member Registry provides access to member records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and Operations Management Area, and "publish and subscribe" services for business processes that track member eligibility, e.g., Care Management and Perform Applicant and Member Outreach. Among the business processes that will interface with the Member Registry are: - The Determine Eligibility process, which checks the Member Registry for status (e.g., new, resubmission, duplicate) and sends completed member eligibility record to be loaded into Member Registry. - The Enroll and Disenroll Member processes, which send and retrieve member information relating to these processes, such as member's ability to access providers, and plan and	

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	provider preferences – The Perform Applicant and Member, Manage Provider, and Manage Contractor Communications processes, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring these communication processes to prepare notifications – The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member – The Perform Applicant and Member Communication process, which schedules the face to face or phone interview, receives an application, or receives a referral, logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process –All Operations Management business processes, e.g., Manage Member Payment, Edit Claim/Encounter, and Authorize Service – The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information – The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support – Program Integrity Identify and Establish Case and the Care Management Establish Case	

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	processes, which access the Member Registry for member information – Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry.	
Prospective and Current Member Support – *Manage Applicant and Member Communication*	Receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The Perform Applicant and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues.	1
Prospective and Current Member Support – *Manage Member*	Handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Applicant and Member Communication process via theReceive	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Grievance and Appeal	Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the Send Outbound Transaction Process.This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited. States define "grievance" and "appeal" differently due to state law, however, States must enforce the Balance Budget Act requirements for grievance and appeals processes through their MCO contracts (42 CFR Part 438.400), and may adopt these for non-	

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	MCO programs.	
Prospective and Current Member Support – *Perform Population and Member Outreach*	Originates internally within the Agency for purposes such as:- Notifying prospective applicants and current members about new benefit packages and population health initiatives- New initiatives from Program Administration- Indicators of underserved populations from the Monitor Performance and Business Activity process (Program Management).It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction and the Manage Business Relationship Communication process. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process. The Perform Population and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues. Inquires from applicants,	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication.	

3.1.3 Capability Maturity Findings

The Member Management area appears to be performed through a series of primarily manual operations, with a medium amount of automation available. The current Member Management area is one in which manual processing still remains the norm for many business processes. The State has made concerted efforts to automate many of the processes and is in the midst of rolling out additional automation that will assist in streamlining the Member Management business area. This is especially evident in the Enroll and Disenroll Member process, where, within the last six months, formerly manual data entry has been moved to an automated interface with AIM for approximately 80% of the time.

There is room for growth in streamlining and automating the identification, enrollment, disenrollment, management, communication and grievance and appeals processes. The review of material and validation with State staff lead to the conclusion that the Member Management area is functioning at a MITA Maturity Level 1.

Current Capability Provider Association Focus Group Comments

At the Provider Association Focus Group session that was held as a part of the MITA Assessment, Member Management issues were the primary area of concern for provider representatives. Many indicated that it takes clients many months to complete the eligibility process. The representatives were clear on their recommendation that Member eligibility and enrollment processes are critical to quality of care, and barriers to eligibility must be addressed before additional steps can be taken to realize the Envisioned Future.

Business Process Findings

The following are findings for Member Management Business Processes:

Eligibility Determination – Determine Eligibility

An eligibility modernization project roll-out is in progress. As a result, standardization for determining eligibility has begun to take place. The modernization project will not fully automate the process. However one of the goals is to improve customer service.

Currently, in the determine eligibility process, staff manually research, validate and respond to requests on a case-by-case basis. This data is entered directly into Indiana Client Eligibility System (ICES). Also, via automated data exchange process, external databases such as SSA and Workforce Development update the ICES.

By law, Indiana does not allow electronic signatures, so members are required to print and sign their applications. Some manual data entry work is required by staff, for example walk-ins or mailed paper applications (which are optically scanned). Once an application is submitted, it may take

up to 45 days for processing and eligibility determination. This timeframe follows acceptable federal standards.

Enrollment – Disenroll Member

The Disenroll Member process is primarily automated, with information not manually re-verified. When a member is disenrolled due to the member becoming ineligible, the disenrollment is system generated and is processed without manual intervention. All other disenrollment requests (not due to member ineligibility) are manually processed by Indiana Enrollment Broker (IEB) staff. Once the disenrollment determination has been made, members are disenrolled from Medicaid eligibility fairly quickly. This also holds true for those enrolled in health plans and programs.

Within Indiana, disenrollment data and formats are standardized and records are centralized. Additionally, a large staff is not required to complete the Disenroll Member process, because there are minimal disenrollments occurring. As a result of how the current process is set up, Indiana does not require staff to proactively identify potential ineligible members. Instead, staff may disenroll a member when redetermination occurs.

Enrollment – Enroll Member

The Enroll Member process for new members is automated. Once eligibility has been determined, a member is enrolled in an overnight process in Indiana AIM without an additional need for an enrollment form. Indiana is in the process of transitioning to a completely centralized system. Monthly synchronization occurs among health plans, enrollment brokers, and Indiana AIM.

Enrollment information is not manually validated and verified, it occurs when data is transferred from ICES to Indiana AIM. The validation is automated by this process.

Member Information Management – Inquire Member Information

Automation has resulted in Indiana having an Inquire Member Eligibility process that appears to be the most accessible, available and efficient of all Member Management processes. The use of Web Interchange and Automated Voice Response System (AVRS) has resulted in a streamlined and efficient approach. It should be noted that the member information is not utilized for the coordination of benefits, which would be advantageous.

Prospective and Current Member Support – Manage Member Information

The current Manage Member Information process is a combination of manual and automated processes. Indiana staff is utilized to manually key new information, make data updates, reconcile and validate data. The Indiana process is not entirely manual though, because automated updates are made to individual files and databases. Member information is maintained and available primarily on a scheduled or request basis to other processes. It should be noted that audit trails for the Manage Member Information process are adequate, because if an audit is required, different systems are available for usage.

Prospective and Current Member Support – Manage Applicant and Member Communication

Members can communicate through the phone, fax, mail, or web. Semi-automated steps take staff through processing for each type of communication. Extensive call center scripts have been created to ensure that information is being conveyed accurately to members.

Prospective & Current Member Support – Manage Member Grievance and Appeal

The Grievances and Appeals process is primarily manual, with a number of steps to be followed, resulting in a time-consuming process. This has resulted in some issues with not always completing cases in a timely manner. Tracking of cases in the grievance and appeal process is not robust. It would be to Indiana's advantage to develop better tracking of these cases to ensure timeliness.

Currently, all health plans utilize an electronic medical management system for their grievance and appeal process. The process for eligibility appeals is conducted utilizing ICES. During the Grievance and Appeal research process, the staff examines both electronic and hard copy client files. As a result, research is a mix of paper and on-line. Moving away from a paper, manual process and into one that is electronically driven will reduce time spent and improve the overall process. Overall, the documentation shows that the Grievance & Appeal process is reasonably standardized, but not automated.

Prospective and Current Member Support – Perform Population and Member Outreach

Member outreach processes are primarily manual, with materials being distributed at locations across the State, such as doctor's offices. In addition, some outreach and educational materials are also available on the web. Because of stringent OMPP guidelines, member outreach and education materials are functionally, linguistically, and culturally appropriate.

3.1.4 Strengths and Weaknesses for Current Business Processes

The current Member Management area is dominated by manual processes. Automation is beginning to be introduced into many of the processes which will help raise the maturity level and provide greater efficiency and accuracy of results in the future.

Strengths in Current Processes

Key Strengths within the existing processes include:

- A modernization project roll-out is in progress at this time with roll-outs to Marion, Lake, and St. Joseph regions left to occur.
- For the Enrollment Broker, formerly manual data entry has been moved to approximately 80% automated interface with AIM within last 6 months. Additionally, there are plans to build an interface and test errors in the future.
- For streamlining and consistency processes, the Enrollment Broker vendor has taken steps to develop extensive scripts for staff to provide proper information when communicating with members.
- Overnight, automated process between eligibility (ICES) and claims (MMIS – IndianaAIM)
- Stringent OMPP guidelines have ensured that member outreach and education materials are functionally, linguistically, and culturally appropriate.

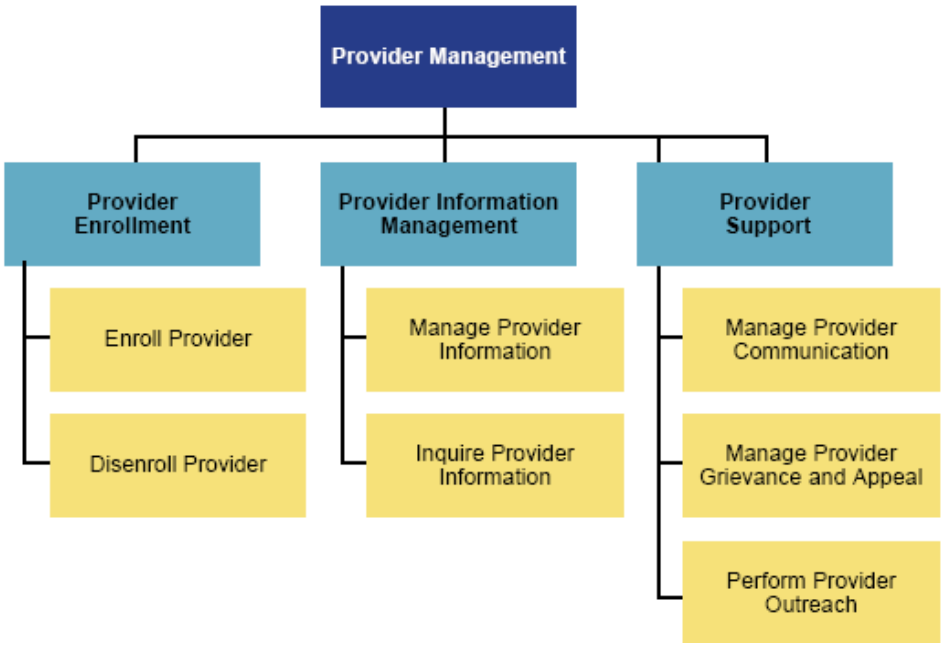
Weaknesses in Current Processes

Weaknesses include:

- The enrollment application for a new member can take up to 45 days to be processed. It should be noted that although the 45 days falls within the Federal permissible timeframe, the ideal situation would be to create a shorter processing time.
- The waiver program maintains its own system, which partially communicates with Indiana AIM. However, the process is not completely automated and the program remains siloed.
- Many business processes, including communication and grievances and appeals, are manual. This results in processes that are time consuming and staff intensive and often have a negative impact on data availability and accuracy.
- The Determine Eligibility process is a staff-dependent, manual process. Staff is often overwhelmed by the amount of work and members possibly experience a delay.

3.2 Provider Management

3.2.1 Business Area and Business Process Description



The Provider Management business area is a collection of business processes that focus on recruiting potential providers, supporting the needs of the population, maintaining information on the provider, and communicating with the provider community. The goal of this business area is to maintain a robust provider network that meets the needs of both beneficiaries and provider communities and allows the State Medicaid agency to monitor and reward provider performance and improve healthcare outcomes.

The Provider Management business processes cover many types of providers. In this case, Enroll Provider may subdivide into Enroll Institutional Provider, Professional Provider, Pharmacy, Durable Medical Equipment (DME), Atypical, and

other types. These groups are types together in the BPM because they share a common set of activities, though the business rules and specific data associated with each provider type may differ.

3.2.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	**Process Description**	**Aggregated Capability Maturity Level**
Provider Enrollment – *Disenroll Provider*	The Disenroll Provider business process is responsible for managing providers' enrollment in programs, including: - Processing of disenrollment -- Requested by the provider -- Requested by another Business Area, e.g., the Manage Provider Communication, Monitor Performance and Business Activities, and Program Integrity Manage Case processes -- Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process -- Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements --- Provider fails enumeration or credentialing verification --- Provider cannot be enumerated through NPPES or state assigned enumerator --- Lack of applicable rates --- Inability to negotiate rates or contract	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	– Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate) – Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records – Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry – Prompting the Manage Provider Communication process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process – Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including -- The Capitation and Premium Payment Area -- The Prepare Provider EFT/Check process – Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS – Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members	
Provider Enrollment – *Enroll Provider*	The Enroll Provider business process is responsible for managing providers' enrollment in programs, including – Receipt of enrollment application data set from the Manage Provider Communication process– Processing of applications, including status tracking (e.g., new,	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance- Validation that the enrollment meets state rules by -- Performing primary source verification of verifies provider credentials and sanction status with external entities, including:--- Education and training/Board certification--- License to practice--- DEA/CDS Certificates--- Medicare/Medicaid sanctions--- Disciplinary/sanctions against licensure--- Malpractice claims history--- NPDB and HIPDB disciplinary actions/sanctions-- Verifying or applying for NPI enumeration with the NPPES-- Verifying SSN or EIN and other business information- Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill- Establish payment rates and funding sources, taking into consideration service area, incentives or discounts- Negotiate contracts- Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations- Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry - Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including:-- The Capitation and Premium Payment Area-- The Prepare Provider EFT/Check process-- The appropriate communications and outreach and education processes for follow up with the	

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	affected parties, including Informing parties of their procedural rights- Perform scheduled user requested:-- Credentialing re-verification-- Sanction monitoring-- Payment rate negotiations-- Performance evaluationExternal contractors such as quality assurance and credentialing verification services may perform some of these steps	
Provider Information Management – *Inquire Provider Information*	The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.	2
Provider Information Management – *Manage Provider Information*	The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid.The Provider Registry is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider Registry may store records or pointers to records for services requested and services	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	provided; performance, utilization, and program integrity reviews; and participation in member care management.Business processes that generate prospective or contracted provider information send requests to the Member Registry to add, delete, or change this information in registry records. The Provider Registry validates data upload requests, applies instructions, and tracks activity. The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services. Among the business processes that will interface with the Provider Registry are- The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status- The Provider Support processes, such as Manage Provider Communication- All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check- The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information- Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information - Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry	
Provider Support - *Manage Provider*	The Manage Provider Communication business process receives requests for information, provider publications, and assistance from	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Communication	prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. Note: Inquires from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.	
Provider Support – *Manage Provider Grievance and Appeal*	The Manage Provider Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.This process	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define "grievance" and "appeal" differently, depending on state laws. This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.	
Provider Support – *Perform Provider Outreach*	The Perform Provider Outreach business process originates internally within the Agency in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, changes in the Medicaid program policies and procedures.For Prospective Providers not currently enrolled, provider outreach information is developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers).For Providers currently enrolled, information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction. All outreach communications and	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.	

3.2.3 Capability Maturity Findings

The Provider Management area appears to be performed through a series of primarily manual and paper based processes, with a minimal amount of automation and web-based services available.

Although standardization has begun to take place, the enrollment and disenrollment process for providers is primarily a manual one, requiring vendors to complete the procedure. This manual effort required by staff creates a delay in the process that would not occur if the process was automated. The communication with providers is also primarily manual, as is the grievances and appeals process. The manual processes add time and cost onto the State and reduces data accuracy and efficiency. The one Provider Management process that appears to be moving closer to automation is that of Provider Information Management – Inquire Provider Information. Processes implemented using the new MMIS Web Interchange and AVRS are more streamlined and efficient. It is advantageous that the vendor completes work and research within OMPP databases, thus eliminating the need to re-enter data and reducing errors.

Because the communication with providers is primarily manual, it makes it more difficult to regulate and ensure the proper information is being disseminated. Effective communication and information exchange is critical for building and managing strong business relationships, public-private partnerships and vendor performance management. The current Indiana Medicaid Enterprise process relies heavily on external business relationships, thus making it critical that the State maintains high levels of communication as it attempts to achieve its Envisioned Future.

The majority of business processes under Provider Management are functioning at a Maturity Level 1.

Provider Association Focus Group Comments

The Provider Association Focus Group noted that the current provider enrollment process is too complicated and inefficient. The process is cumbersome, duplicated across several different divisions in FSSA and across multiple vendors, such as EDS and HMO's. Providers have to submit many different applications and forms multiple times to get enrolled. Providers have varying amounts of ***paperwork*** to submit to OMPP, HMO's, Aging and EDS, in order become credentialed It is a burdensome, redundant, costly and frustrating process. Additionally, the group noted that the disenrollment process was also at times difficult. There have been instances where providers have been asked to be disenrolled from the program, but continue to have members contact them to see if they are accepting new patients because the provider appears as enrolled in the MMIS.

Business Process Findings

The following are findings for business processes within the Provider Management Area according to the validation session and review of current material. These findings are specific to the process developed involving EDS:

Provider Enrollment – Disenroll Provider

When disenrolling a provider, the process remains primarily manual. Currently, disenrolling a provider is not a part of the web program and staff is required to manually enter the information for disenrollment. As of July 1st, 2008, all providers will able to do provider updates to existing records. The goal date to be fully automated is January 2009. At the present time, licensing staff do maintain a web registry of licensed doctors, enabling licensure to be verified by using the web.

Provider Enrollment – Enroll Provider

The current Provider Enrollment process is one in which manual processes are the norm. Standardization for enrolling providers has begun to take place, but automation of the process still does not exist. For example, providers do not have the option to submit their enrollment electronically via a portal, which would greatly improve turnaround time and reduce an unnecessary paper trail. The manual validation and updating process of enrolling members also continues to rely heavily on vendor staff. As a result of these manual processes, updates are not immediate and there may be a delay in providing accurate provider information. On July 1st, 2008, providers will be able to access existing records via the web, although modifications will not be able to be made.

Provider Information Management – Inquire Provider Information

The Provider Information Management – Inquire Provider Information process has been streamlined by providing each provider with an IHCP provider number. This has allowed for providers to make use of a web portal. The Web Interchange has become a critical component to the process, functioning as an interactive Web application that allows providers to access the IHCP system through the Internet. The usage of the Web Interchange has resulted in a more streamlined and efficient process, that requires fewer staff. Providers also have the option to utilize AVRS when inquiring about provider information. The usage of these systems together results in quicker turnaround time and more accurate responses than the utilization of program management staff.

Provider Information Management – Manage Provider Information

Currently, any updates to the provider information occur as a manual process, completed by staff. Information is occasionally updated through an automated process on Web Interchange. Automation should be fully implemented as of July 31st, 2008.

Provider Information Management – Manage Provider Communication

When communicating with providers, the correspondence from the State is most likely verbal, written, or email. This results in the overall response time varying, with some responses taking longer. One approach the State has taken to reduce response time and inconsistencies is to expand the utilization of Web Interchange and AVRS.

Provider Support – Manage Provider Grievance and Appeal

The Grievance and Appeal process is a manual process. Within each provider, staff research and maintain grievance and appeal information manually, resulting in a labor-intensive process.. Each partner is required to have a grievance and appeal process, which must be followed should a provider have a grievance or appeal. If the grievance or appealed has not been resolved through this process, then providers have the option to file a grievance and/or appeal with FSSA's Division of Hearing and Appeals.

Provider Support – Perform Provider Outreach

Overall, the current Outreach business process was assessed as a Level 1, as the current capabilities are limited. However, the State has made an effort to ensure cultural standards and quality improvement measures are in place. For example, it is a requirement that all providers have in place culturally sensitive standards and rules. This helps to ensure that providers function within a culturally correct environment and make efforts to create cultural and linguistic matches for their clients. Quality assurance and monitoring are completed to ensure provider satisfaction.

3.2.4 Strengths and Weaknesses for Current Business Processes

According to the validation session, OMPP and EDS have been working to streamline and improve the Provider Management Business Processes. By early 2009, it is anticipated that a majority of the business processes with EDS will be able to be conducted over the MMIS Web interchange portal. Current processes rely on manual processes and are not as efficient.

Strengths of Current Processes

Key Strengths within the existing processes include:

- As of July 31st, 2008, providers will be able to update provider enrollment information via the web.
- The Provider Information Management – Inquire Provider Information process was measured at a Maturity Level 2.
- The utilization of the Web Interchange for the Provider Information Management – Inquire Provider Information process has resulted in a more streamlined and efficient process.
- The Provider Information Management – Inquire Provider Information process has been streamlined by providing each provider with an IHCP provider number. This has allowed for providers to make use of a web portal. The Web Interchange has become a critical component to the process, functioning as an interactive Web application that allows providers to access the IHCP system through the Internet. The usage of the Web Interchange has resulted in a more streamlined and efficient process, that requires fewer staff.
- The NPI is the ID of record for the majority of providers, resulting in a standardized ID.
- The Provider Support – Manage Provider Information process was measured at a Maturity Level 2.
-

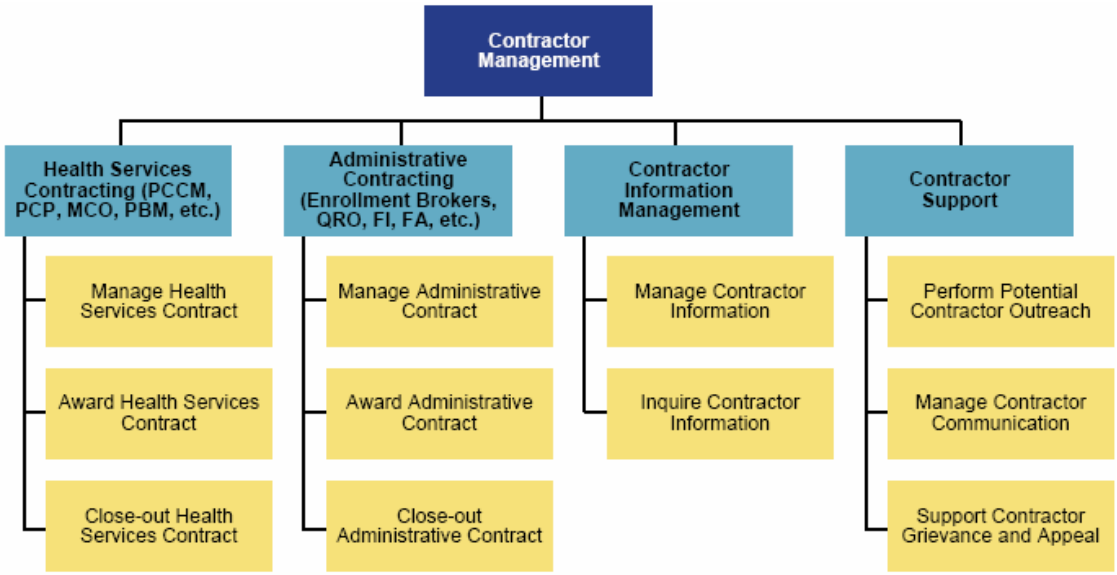
Weaknesses of the Current Processes

Weaknesses include:

- Although automation is in the works, the enroll and disenroll provider processes remain primarily manual. For disenrollment of providers, there is the potential for errors to occur because of manual data entry. Full automation of enrollment and disenrollment will not occur until January 2009.
- The monitoring and re-verification of enrolled providers' status is a reactive, not proactive, process.
- There is a lack of documented processes for the Provider Support - Perform Provider Outreach process.
- Provider Enrollment is a siloed program-specific process and does not have enterprise standards, approaches or documented processes for enrollment and disrollment. Providers discussed the challenges that presents for a provider in having to complete several disconnected enrollment processes where the same or similar information is collected for enrollment. This is duplicative, time consuming and costly.
- The Grievance and Appeal process is a manual process, with no plans for automation in the queue.

3.3 Contractor Management

3.3.1 Business Area and Business Process Description



The Contractor Management business area accommodates States that have managed care contracts or a variety of outsourced contracts. Some States may, for example, group Provider and Contractor in one business area. The Contractor Management business area has a common focus (e.g., manage outsourced contracts), owns and uses a specific set of data (e.g., information about the contractor or the contract), and uses business processes that have a common purpose (e.g., solicitation, procurement, award, monitoring, management, and closeout of a variety of contract types). Creating a separate business area for Contractor Management allows the MITA BPM to highlight this part of the Medicaid enterprise, which is becoming increasingly important to State Medicaid agencies. Indeed, it is the primary focus in some States that have comprehensive managed care or multiple-contractor operations.

In the Contractor Management business area, the many types of healthcare service delivery contracts (e.g., managed care, at-risk mental health or dental care, primary care physician) and the many types of administrative services (e.g., fiscal agent, enrollment broker, Surveillance and Utilization Review [SUR] staff, and third-party recovery) are treated as single business processes because the business process activities are the same, even though the input and output data and the business rules may differ.

3.3.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	**Process Description**	**Aggregated Capability Maturity Level**
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – *Award Administrative Contract*	The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses.	1
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – *Close-Out Administrative Contract*	The Close-out Administrative Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – *Manage Administrative Contract*	The Manage Administrative Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	1
Contractor Information Management – *Inquire Contractor Information*	The Inquire Contractor Information business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.	1
Contractor Information Management – *Manage Contractor Information*	The Manage Contractor Information business process receives a request for addition, deletion, or change to the Contractor Registry; validates the request, applies the instruction, and tracks the activity.	1
Contractor Support – *Manage Contractor Communication*	The Manage Contractor Communication business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process. NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process by providing assistance and responses to individual entities, i.e., bidirectional communication. The	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.	
Contractor Support – *Perform Potential Contractor Outreach*	The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the Send Outbound Transaction. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.	1
Contractor Support – *Support Contractor Grievance and Appeal*	The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process. This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define "grievance" and "appeal" differently, perhaps because of state laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.	
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – *Award Health Services Contract*	The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.	1
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – *Close out Health Services Contract*	The Close-out Health Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	1
Health Services Contracting (PCCM, PCP,	The Manage Health Services Contract business process receives the contract award data set, implements contract monitoring procedures, and	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
MCO, PBM, etc.) – *Manage Health Services Contract*	updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	

3.3.3 Capability Maturity Findings

The Contractor Management Area within the Indiana Medicaid Enterprise is a combination of manual and automated processes. Automation is used as a support mechanism for the development and tracking of contracts. Our assessment of the Contractor Management area reveals that it appears to be performed through a series of manual and paper based operations with some transparency of overall process flow provided to those divisions and staff that have access and authority to review both the Contract Management System (KMS) and the PeopleSoft System. With regard to PeopleSoft, the Financial Module is the only area where contract information is currently found, however there are plans to implement a full contract module (Supplier Management Module) in the near future. It was also stated during the validation sessions that while all executed contracts culminate in paper document imaging at the IDOA level, the current vendor for imaging does not image or scan all pieces of the contract. This has now resulted in the creation of a duplicative process at the OMPP and other division level, whereby all documentation is scanned and loaded to a central SharePoint site so that all components of the executed contract are available. This clearly is a process that needs to be looked at as it is inefficient and costly.

Although there are some standardized elements for Contractor Management Business Processes, particularly with regard to the Award Contract, Manage Contract Information, and Support Contractor Grievance and Appeals processes, many processes do not appear to have written, desk level procedures. This was confirmed during the validation sessions, as the team noted that there were processes in each division, but most were informally documented. Informally, OMPP, DMHA, DDRS, DA and DFR representatives try to meet bi-weekly to discuss Contractor Management and Business Relationship Management issues and have attempted to create and adopt standardized processes and procedures. This has helped to provide some level of consistency in the Contractor Management business processes related to Award, Closeout, Grievance, and Communication related business processes. Manage Contract processes (both Administrative and Health Services) are handled at the business program owner level and are not discussed at the bi-weekly meeting.

As stated above, many Contractor Management processes are not handled at the Medicaid Enterprise level after the point in time that a contract has been awarded and executed. There is additional information provided with regard to how various entities manage their relevant contractors (i.e. PBM, EDS, Enrollment Broker), but there is not one standard process or transparency into the process from a consolidated Medicaid Enterprise view. Some business processes such as Perform Contractor Communications and Perform Contractor Communications Outreach had limited to no documentation present to describe how the process is conducted in Indiana. Through the Validation sessions, it was determined that these processes occur at the IDOA level as well as informally at the division level.

The overall Contractor Management Business Area remains constrained by a largely paper-driven series of processes that are highly dependent on manual review and approval of forms. While we know that staff within the Indiana Medicaid enterprise performs these processes (as evidenced by the verbal description of how things happen given during the validation sessions), capability maturity for processes without written procedures must be documented at a level 1, as the process is not inherently repeatable

Provider Association Focus Group Comments

There were no comments or discussion of the Contractor Management Business Area provided at the Provider Association Focus Group meetings

Business Process Findings

The following are assessment findings for Contractor Management Business Processes:

Administrative and Health Services Contracting – Award Contract

Contracting in Indiana is administered through the Indiana Department of Administration (IDOA) with support and assistance from the Budget Agency, the Indiana Office of Attorney General (IOAG), and for IT related contracts, the Indiana Office of Technology (IOT). The Award Contract process in Indiana starts at the Business Owner who has a business need for contracted services (either administrative or health services related). The Business Owner works with their contract specialists and legal specialists to determine the most appropriate contracting mechanism and works to develop the business requirements for the procurement document (RFS, RFI, etc.) and contract. IDOA works with each division or agency to ensure that

the resulting procurement, evaluation method and contract follow the guidelines established in the Indiana Contract Manual.

While there is a consistent, global process for all agencies in Indiana to request a contract be created and awarding of a contract, many of the components of the process still rely on paper documents being passed around to multiple entities for review and signature including IDOA, Budget Agency, IOAG, and in some cases IOT. This may cause delays to the contract approval process that may significantly affect how long it takes to award or amend a contract in Indiana, depending on how many approvals are needed.

The overall Award Contract process was assessed at MITA Maturity Level 1, as there were a majority of capabilities and characteristics affirmed at level 1, with some characteristics such as Utility to Stakeholders achieving Level 2 due to the use of a standardized, consistent process for contract development and award. There were a few characteristics affirmed at Level 3 related to the Data Access and Accuracy as well as Effort to Perform due to Indiana's use of a standardized consistent process instead of a division-specific siloed process, which improves data accuracy and overall efficiency for the Award contract process.

Administrative and Health Services Contracting – Close-Out Contract

The Indiana Medicaid Enterprise follows a very detailed Contract Manual published by IOAG and IDOA for use by all Indiana agencies and divisions that provides numerous contract clauses that are part of all Indiana contracts. The termination clauses provide all of the reasons or methods that either the State of the vendor may terminate or close out a contract. Review of the Contract manual and other Contractor Management documentation did not reveal a desk level procedure that provides the step

by step process for a business owner to follow should he/she need to terminate or close a contract.

During the validation sessions, it was noted that there are three main reasons for contract termination – contract ends, termination for convenience, and termination for contractor default. Most terminations or closeouts occur at the contracted end date for a contract, however, in the case where there has been a reason to terminate the contract early, generally the process includes the business owner sending an email to the contract specialist or legal specialist to determine the appropriate clause to invoke for the close out. Once the proper clause has been determined, the process follows the contract language in terms of sending out formal notice to the vendor and providing (if appropriate), instructions surrounding options to "cure" any breach or deficiency. The letter to the contractor can be sent by either IDOA or the division. At the point that the contract is to be closed, the agency/division coordinates with IDOA to finalize the close out process for both Administrative and Health Services contracts. The group stated that the terminate or close out process is consistent among the entire Indiana Medicaid Enterprise.

The Close Out Contract process was assessed as MITA Maturity Level 1, based on the affirmation of characteristics at Level 1 and the lack of a documented desk level procedure for business owners or other staff who manage contracts to follow. There were no characteristics assessed at Level 2 and one characteristic (Accuracy of Processing Results) assessed at Level 3, as all divisions must follow the IDOA Contract Manual guidelines for termination clauses in a contract.

Administrative and Health Services Contracting – Manage Contract

The Manage Contract business processes for both Administrative and Health Services Contracts are performed at the Business Owner level. For administrative contracts, there are various, program-owner level performance reporting conducted on weekly, monthly or quarterly basis. The entire process is not universally documented and can vary not only between FSSA divisions who manage Medicaid administrative or health services contracts, but also can vary within a given division for administrative contracts. Health Services contracts are managed by the business or program owners as well and have some required performance reporting that is provided as "self reported" performance reporting from the MCOs and CMOs. This information is not necessarily independently verified by OMPP or other FSSA divisions and is assumed to be an accurate report of key performance indicators.

The Manage Contract business process was assessed overall at MITA Maturity Level 1 as all Level 1 capabilities and characteristics were affirmed. There were also a few characteristics assessed at Level 2 related to timeliness and data accuracy of the process.

Contractor Information Management – Inquire Contractor Information

Indiana uses a standard process to respond to inquiries regarding existing contracts. There is a documented procedure for this process. At the validation sessions, the group discussed that there is a standard, namely the "IQ" process that each division utilizes for resolving inquiries on contractor information; however it was not clear that all divisions were in fact using the process. OMPP does utilize the IQ system for all inquiries. The "IQ" process includes documenting the inquiry into the IQ system and determining what

type of staff need to respond to the inquiry. For contractor information, if the inquiry is received at the FSSA Communications department level, it goes to the appropriate single point of contact at the appropriate Indiana Medicaid Enterprise agency/division for resolution. Certain responses require the Medicaid Directors signature before being released to the requestor, although the criterion for determining which inquiries require this was not found in the documentation.

Overall, the Inquire Contractor Information process was assessed at MITA Maturity Level 1, due to a majority of characteristics being affirmed at Level 1. There were some characteristics such as improvements to data access and accuracy, effort to perform the process and automation that achieved Level 2 due to the automation provided by the IQ process and system. Additionally, two characteristics were affirmed at Level 3 related to efficiency to perform the process (due to the widespread access to the IQ system across the enterprise) and the ability to obtain continuously refreshed contractor data from KMS, PeopleSoft, and SharePoint to allow for accurate responses.

Contractor Information Management – Manage Contractor Information

The Manage Contractor Information process is conducted by both the division responsible for the contract and IDOA. There was no documented procedure for this business process, however at the validation session, it was stated that this process occurs at both the division level and the Auditor level depending on who is contacted about changes to contractor information. Changes are made to the CMS and PeopleSoft (if appropriate)

systems and the SharePoint site that has been developed to store all contract related documents.

The Manage Contractor Information process was assessed overall at MITA Maturity level 1 due to a majority of capabilities and characteristics being affirmed at Level 1 and due to the lack of a documented desk level procedure. There were a few characteristics affirmed at Level 2 related to improvements in timeliness of the process and standardized use of the EDS form for updates. There was also one characteristic affirmed at Level 3 related to the utility to stakeholders as collaboration and consistency among agencies is improved by use of the EDS form and a single process for Managing Contractor Information.

Contractor Support – Manage Contractor Communication

There was no documented procedure for this business process, however at the validation session, it was stated that this process occurs both at the division level and at the IDOA level. In general, IDOA is responsible for and handles all global communications with the vendor community. It was noted that when it is necessary to disseminate a message to any contractor in Indiana, it is possible, depending on how many contracts the vendor has, that the same (or similar) message or communication is transmitted multiple times. This would occur only in the instance where IDOA chooses to delegate the communication to the divisions for dissemination and where a vendor has contracts with multiple divisions or agencies. The messages are often similar, but have division specific information provided for the vendor.

The Manage Contractor Communication process was assessed overall at MITA Maturity Level 1 due to not all characteristics being able to be affirmed

at Level 2. A majority of capabilities and characteristics were affirmed at Level 2, however since there was no overall documented process and the characteristics related to use of standardized communications template between the Indiana Enterprise and Contractors could not be affirmed. One characteristic was affirmed at Level 3 related to improved Data Accuracy in communications due to the use of United States Postal Service (USPS) address standards when mailing out notices to contractors.

Contractor Support – Perform Potential Contractor Outreach

There was no documented procedure for this business process, however at the validation session, it was stated that this process can occur both at the division level and at the IDOA level when the enterprise is considering issuing a Request for Services (RFS) or a Request for Information (RFI). Additionally, it was stated that there are ad hoc outreach efforts done at the division level when there is a need to garner ideas for or input into an upcoming RFS. The primary mechanisms used for this process are telephone, email and via notice on the IDOA website.

The Perform Potential Contractor Outreach process was assessed overall at MITA Maturity Level 1 due to the lack of a documented process and due to the affirmation of two characteristics at Level 1 (quality of data communicated during outreach related to an upcoming RFS and the possibility of uncoordinated outreach to contractors by division) while all others were assessed at Level 2 and in some cases Level 3. A majority of the characteristics were affirmed at Level 2, based on the Validation session discussion of how the process occurs in day to day operations. A few characteristics related to Effort to Perform the process and cost effectiveness

were affirmed at Level 3, based on automation that has been introduced into the process.

Contractor Support – Support Contractor Grievance and Appeal

The Support Contractor Grievance and Appeal process in Indiana is outlined in each contract that is executed and is based on Indiana code. This process has a very defined series of steps, usually outlined in any contract executed by OMPP or any other division within the Indiana Medicaid enterprise. It is conducted in a series of steps that occur at first at the business/program owner level, then the appropriate director level, followed by the division level and ultimately the IDOA level. The goal is to resolve complaints by contractors before they become grievances and rarely has the enterprise experienced a complaint running the entire length of the process (i.e. becoming a grievance, then if needed an appeal) before resolution. The process is well documented and followed by all FSSA divisions. Contractors are made aware of the process via the Contractor handbook as well as the language found in the executed contract.

The Support Contractor Grievance and Appeal process was assessed overall as MITA Maturity Level 1, due to the process being mostly paper based and involving manual research. There were quite a few characteristics affirmed at Level 2 due to improvements in timeliness, cost effectiveness and accuracy in the process in recent years. Characteristics affirmed at Level 3 related to access to program rules (Indiana Code) via the web and also data access and accuracy. This process also had one characteristic affirmed at Level 4 related to transparency and availability of grievance and appeals rules (Indiana Code) via the IDOA website.

3.3.4 Strengths and Weaknesses for Current Business Processes

In the past, both the State of Indiana and FSSA have targeted strategic priorities on reforming and streamlining their contracting processes. The enterprise noted that great success has been evidenced, with an increase in "on time" contracts rising from less than 20% to approximately 85%. In addition, OMPP has key personnel who are dedicated to improving Contractor and Business Relationship Management. They have created databases to track contracts and perform some ad hoc reporting capabilities. The PeopleSoft implementation will improve part of this functionality, yet there are many steps outside of this automated process that are completely dependent on paper processes, and staff decision-making without timelines or alerts to ensure the process continues to move forward in an effective and efficient manner. The current process relies on dedicated staff who follow-up at least weekly, if not daily to ensure that the process continues to move forward.

Strengths in Current Business Processes

Key strengths within the existing processes include:

- Consistent set of rules and process for creating and amending a contract.
- Transparency into the contracting process with the use of the Contract Management Tracking System (KMS).

- Transparency into contractor data once a contract is executed via access to CMS (Contract Management System). Once the PeopleSoft Contract Module (Supplier Management Module) is launched there will be additional advantages to the enterprise.

- Well defined procurement and contracting process, managed by IDOA, IOAG, and IOT (if necessary).

- Well documented and defined process for handling contractor Grievance and Appeals.

Weaknesses in Current Business Processes

Weaknesses include:

- No documented processes for the following MITA Business Processes:
  - Close Out Administrative Contract
  - Perform Potential Contractor Outreach
  - Close Out Health Services Contract

- Limited and siloed processes for the following business processes
  - Manage Administrative Contract
  - Manage Health Services Contract

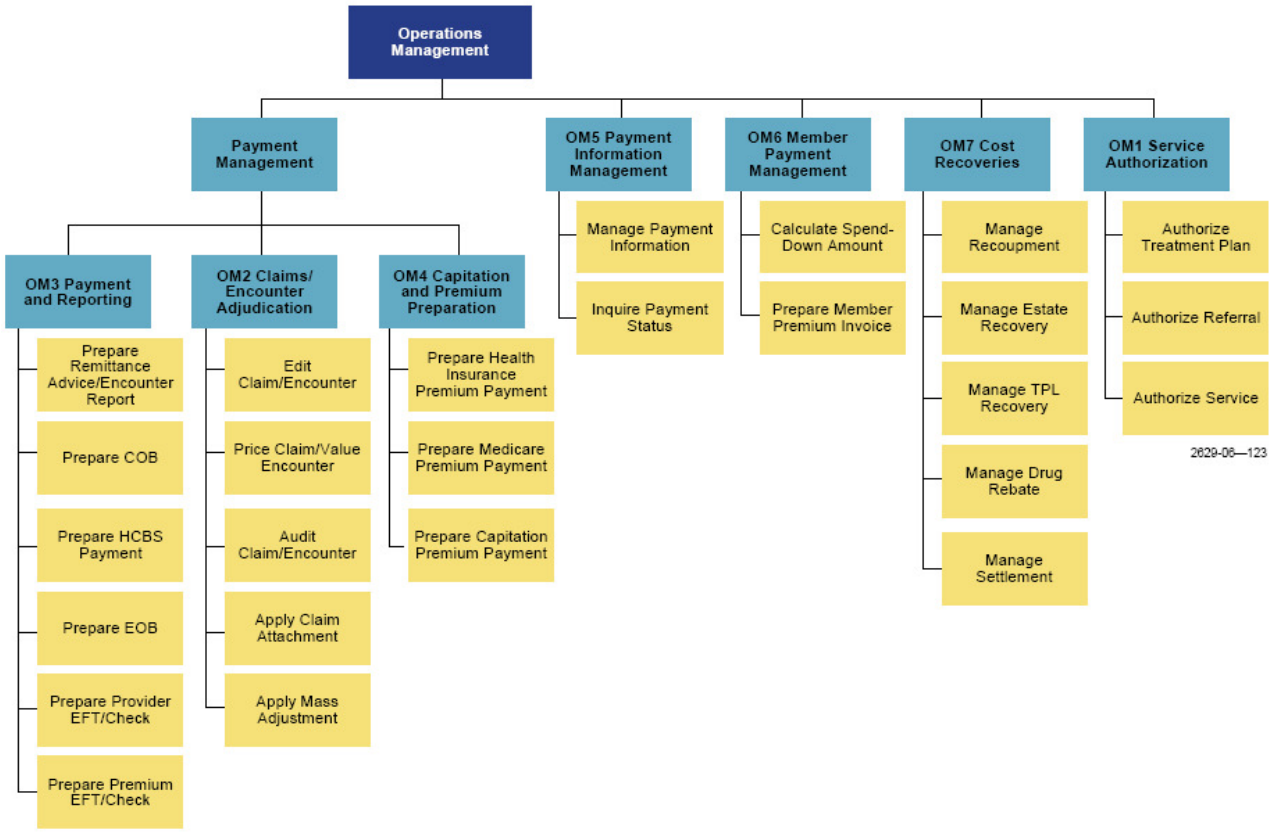
  These two areas have documented process for some of the current contractors, but the process is not consistent between programs.

- Duplication of effort between IDOA vendor (Pitney Bowes) and OMPP and other Divisions in imaging and loading to a common repository of executed contracts. The IDOA vendor (Pitney Bowes) only loads a portion of the contract documents, which is not useful at the division level.

- Lack of process at the enterprise level (IDOA Level) to ensure that the same services are not being requested in multiple procurement efforts within different divisions in the Medicaid enterprise. This process was being handled by a vendor, but will transition to IDOA under the Strategic Sourcing Initiative. There was no documentation of this process from One Indiana and it is not clear how IDOA will take over the process and look not only retrospectively, but prospectively as initiatives are presented for RFS development.
- Lack of coordination of Contractor Communications when a message is necessary and the contractor/vendor has multiple contracts with different divisions within the Indiana Medicaid Enterprise. This happens maybe once or twice a year at most, but the message is division specific. This does not happen on a regular basis.

3.4 Operations Management

3.4.1 Business Area and Business Process Description



The Operations Management business area is the focal point of most State Medicaid enterprises today. It includes operations that support the payment of providers, managed care organizations, other agencies, insurers, and Medicare premiums and support the receipt of payments from other insurers, providers, and member premiums.

This business area focuses on payments and receivables and "owns" all information associated with service payment and receivables. Most States have automated operations that support these payments. In fact, this is probably the part of Medicaid that is most representative of all State Medicaid programs.

Common business processes include validating requests for payment and determining payable amount; responding to premium payment schedules and determining payable amount; and identifying and pursuing recoveries.

3.4.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
OM1 – Service Authorization – *Authorize Referral*	The Authorize Referral business process is used when referrals between providers must be approved for payment. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. Referral authorization usually occurs in certain provider network and managed care settings. Authorize referrals closely follows the details of Authorize Service and may not require a separate business process definition.	1
OM1 – Service Authorization – *Authorize Service*	The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting. The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment,	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary. After review, a referral is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication. A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made. A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes. NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, Inpatient, Out-of-State Services, and Emergencies.	
OM1 – Service Authorization – *Authorize Treatment Plan*	The Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time. A service request is more limited and focuses on a specific visits, services, or products. The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary. After reviewing; approves, modifies, pends or denies the request and sends the appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the Manage Provider Communication process or sending a 277 Request for Additional Information to the provider. A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.	
OM2 – Claims/Encounter Adjudication – *Apply Claim Attachment*	This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the Edit Claim/Encounter or Audit Claim/Encounter process or has been sent by the provider (unsolicited) from the Receive Inbound Transaction process, linking it with a trace number to associated claim, stapling to a claim or pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	necessary to adjudicate the claim, and if yes, moving the attachment with claim to the next adjudication process; if no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found. NOTE: If no claim is found, the attachment data set is pended for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.	
OM2 – Claims/Encounter Adjudication – *Apply Mass Adjustment*	The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. This business process often affects multiple providers as well as multiple claims. NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.	1
OM2 – Claims/Encounter Adjudication – *Audit*	The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Claim/Encounter	time limits. Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the Price Claim/Value Encounter process All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.	
OM2 – Claims/Encounter Adjudication – *Edit Claim/Encounter*	The Edit Claim/Encounter E2E business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and- Determines its submission status- Validates edits, service coverage, TPL, coding- Populates the data set with pricing information Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes. NOTE: The Edit	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Claim/Encounter process does not apply to:- Point of Sale, which requires that Edit, Audit, and other processes be integrated, or- Direct Data Entry, On-line adjudication, or Web enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.	
OM2 – Claims/Encounter Adjudication – *Price Claim/Value Encounter*	The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the Manage Payment History process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic. NOTE: An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.	2
OM3 – Payment and Reporting – *Prepare Coordination of Benefits (COB)*	The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. The Prepare COB business process begins with the completion of the Price	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Claim/Value Encounter process. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and/or eligibility files. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the Send Outbound Transaction.	
OM3 – Payment and Reporting – *Prepare Explanation of Benefits (EOB)*	The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims. This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication. NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.	1
OM3 – Payment and Reporting –	Many home and community based services are not part of the traditional Medicaid benefit package.	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Prepare Home and Community-Based Services (HCBS) Payment	Services tend to be client specific and often are arranged through a plan of care. Services for Home & Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers. The Prepare Home and Community-Based Services Payment business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History process for loading into the Payment History Repository. The reimbursement amount is sent to the Manage Provider Information process for loading into the Provider Registry for purposes of accounting and taxes. NOTE: This process does not include sending the home & community based provider payment data set transaction.	
OM3 - Payment and Reporting – *Prepare Premium EFT/Check*	The Prepare Premium EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including- Calculation of-- HIPP premium based on members' premium payment data in the Contractor Registry-- Medicare premium based on dual eligible members' Medicare premium payment data in the Member Registry-- PCCM management fee based on PCCM	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	contract data re: difference reimbursement arrangements in the Contractor Registry-- MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor Registry-- Stop-loss claims payments for MCO's in the Contractor Registry- Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives- Disbursement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules- Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]- Routing the payment per the Contractor Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate.	

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
OM3 – Payment and Reporting – *Prepare Provider EFT/Check*	The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: – Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupment, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the Manage 1099 process – Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues – Disbursement of payment from appropriate funding sources per Agency Accounting and Budget Area rules – Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities – Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction – Updates the Perform Accounting Function	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history – Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS.	
OM3 – Payment and Reporting – *Prepare Remittance Advice/Encounter Report*	The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the pricing, audit and edit processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.	2
OM4 – Capitation and Premium Preparation – *Prepare Capitation Premium Payment*	The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Maintain Member Information, retrieving the rate data associated with the plan from the Manage Provider Information, formatting the payment data into the required data set, which is sent to the Send	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Manage Provider Information for updating. This process does not include sending the capitation payment data set.	
OM4 – Capitation and Premium Preparation – *Prepare Health Insurance Premium Payment*	Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers. The Process Health Insurance Premium Payments business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Member Information for updating. NOTE: This process does not include sending the health insurance premium payment data set.	
OM4 – Capitation and Premium Preparation – *Prepare Medicare Premium Payment*	State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance. The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading. NOTE: This process does not include sending the Medicare premium payments EDI transaction.	1
OM5 – Payment Information Management – *Inquire Payment Status*	The Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	set via the Send Outbound Transaction process.	
OM5 – Payment Information Management – *Manage Payment Information*	The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information Repository, which is the source of comprehensive information about payments made to and by the state Medicaid agency for healthcare services. The Payment Information Repository exchanges data with Operations Management business processes that generate payment information at various points in their workflow. These processes send requests to the Payment Information Repository to add, delete, or change data in payment records. The Payment Information Repository validates data upload requests, applies instructions, and tracks activity. In addition to Operations Management business processes, the Payment Information Repository provides access to payment records to other Business Area applications and users, such as the Manage Program, Member, Contractor, and Provider Information processes, via record transfers, response to queries, and "publish and subscribe" services.	2
OM6 – Member Payment Management – *Calculate Spend-Down Amount*	A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility). The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend down has been met which allows for	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations. The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. NOTE: The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.	
OM6 – Member Payment Management – *Prepare Member Premium Invoice*	Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The Prepare Member Premium Invoice business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	invoices which will be sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Maintain Member Information process for updating. NOTE: This process does not include sending the member premium invoice EDI transaction.	
OM7 – Cost Recoveries – *Manage Drug Rebate*	The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions.	2
OM7 – Cost Recoveries – *Manage Estate Recovery*	Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution. The Manage Estate Recovery business process begins by receiving estate recovery data from	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate lien when recovery is completed, updating Member Registry, and sending to Manage Payment History for loading. NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.	
OM7 – Cost Recoveries – *Manage Recoupment*	The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer. The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the Manage Provider	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Communication, applying refund in the system from the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied. Recoupments can be collected via check sent by the provider or credited against future payments for services.	
OM7 – Cost Recoveries – *Manage Settlement*	The Manage Settlement business process begins with requesting annual claims summary data from Manage Payment History, reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the Send Outbound Transaction process to Manage Provider Communication, Manage Payment History, Manage Rate Setting and sending receivables data to Perform Accounting Functions, and tracking settlement payments.	1
OM7 – Cost Recoveries – *Manage TPL Recovery*	The Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, SUR, Fraud and Abuse units, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	data to Perform Accounting Function, and updating payment history Manage Payment History. NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.	

3.4.3 Capability Maturity Findings

The Operations Management business processes appear to be performed through a combination of manual and automated processes utilizing both paper based operations for some processes and exceptions in other, but largely through EDI processing in Indiana*A/M.* To varying degrees the exchange of data required for Operations Management processes occurs by paper, fax, mail, phone, and EDI HIPAA compliant transactions. Web enabled EDI exchange for these processes appear limited.

The various Operations Management business processes are performed by Advantage and MDWise CMOs, EDS, MCOs, and ACS under vendor contracts. All vendors maintain procedural manuals documenting the business processes required to perform their contracted functions for the State of Indiana Medicaid Enterprise. The one exception to vendor managed operations appears to be OM7 – Cost Recoveries – Manage Estate Recovery which is managed by OMPP. The table below identifies Vendors with their high level business processes:

VENDOR	OPERATIONS MANAGEMENT BUSINESS PROCESS

VENDOR	OPERATIONS MANAGEMENT BUSINESS PROCESS
EDS **CMOs** **MCOs** **Waiver Case Management – IUPMG** **Roeing** *(Waiver)*	OM1- Service Authorization (Prior Authorization)
EDS **MCOs**	OM2 – Claims/Encounter Adjudication OM3 – Payment and Reporting OM4 – Capitation and Premium Preparation OM5 – Payment Information Management OM6 – Member Payment Management
ACS	OM7 – Cost Recoveries – Manage Drug Rebate
HMS	OM3 – Payment and Reporting – *Prepare Coordination of Benefits (COB)* OM7 – Cost Recoveries

The Indiana Administrative Code (IAC 5-3) outlines the provisions under which prior authorization may be provided for Medicaid services. Because all medical service requests for prior authorization are reviewed on a case-by-case basis, Service Authorization processes performed by CMOs consist of a combination of automated and manual processes. Requests may be received in writing, by telephone, or via 278 electronic transactions from the requesting provider reducing the number of manual Service Authorization interventions; however, manual intervention is required for written and phone requests.

Medicaid Claims for all programs are accepted by both electronic and paper claims submission. Paper claims continue to require some manual intervention to convert data for processing in the Indiana*AIM*. Claims and Encounter adjudication processes including edits and audits are performed through automated processing by Indiana*AIM*. Adjudication of suspended claims and exceptions continues to require manual intervention. Claims pricing and payment are primarily automated processes, requiring minimal manual intervention for paper check processing and mailing. Claims inquiries and communications are manual, voice activated and web enabled, web enabled claims payment inquiry systems are available from EDS, but not all MCO's are offering web based payment inquiry services to providers. Premium payment processes continue to require a combination of automated and manual processes. Manual intervention and the use of reports continue to dominate these processes and manual intervention is required to process payments received by check and deposit into the lock box system in use.

The Indiana Medicaid Enterprise complies with Federal regulations and State statutes which mandate cost-containment measures for state health care programs through program of cost avoidance with regard to third party claims. The Indiana Health Coverage Programs (IHCP) must pay claims when third party information is unknown at the time the claim is processed or when the claim meets specific criteria based on federal mandates. The cost recovery process is subcontracted by EDS to HMS. HMS uses Third Party Liability Identification and Billing which obtains eligibility files from insurers, pharmacy benefits managers, third party administrators, Medicare, TRICARE and employer groups on a monthly, quarterly or annual basis. Direct billing is provided through a process of claims review. Disallowance Projects and

payments are manually processed through the receivables lock box operated by Fifth Third.

Member payments are handled through the lock box operations with Fifth Third as well. Most processes related to cost recovery including member payments, TPL and COB including Estate Recovery, Recoupment, and Settlement utilize a combination of automated and manual processes, with invoicing and billing processes more or less automated, payment receipt and accounting processes continue to be primarily manual processes.

Drug Rebate, which is managed by ACS, is the exception to manual processing with most processes being automated utilizing cyclical claims, invoice, payment and resolution processes with the exception of supplemental rebate processing that is managed through a bid process that is largely manual.

Business processes were assessed based on the procedural documentation provided by the agency and vendors. For all of the business processes assessed for Operations Management it was not possible to determine whether or not the vendor services achieve agency performance targets for Timeliness, Data Access and Accuracy, Effort to Perform and Efficiency, Cost-Effectiveness, Accuracy of Process Results or Utility or Value to Stakeholders based on the documentation provided and thus determinations related to the quality of business process capability maturity within these MITA 2.0 parameters could not be made during the initial review. These characteristics were fully assessed during the Current Capabilities Assessment Validation Sessions by OMPP staff and subject matter experts provided by the process vendors.

All Operations Management business processes were assessed to possess some capabilities at MITA Maturity Levels 1, with many processes possessing capabilities at MITA Maturity Level 2 and a few at Maturity Level 3. No Current Capabilities were found to possess characteristics at MITA Maturity Level 4.

Provider Association Focus Group Comments

The Provider Association Focus Group in general had positive feedback regarding current processes in the Operations Management Area. Providers are satisfied with the current FFS claims processing and service authorization processes, but noted that the Managed Care Organizations could improve on their timeliness of reviewing and approving service authorization requests.

The group also noted that payment reporting via 835's operates efficiently today and that payment information is readily available via the AVRS system. There were some concerns raised about claim payment accuracy, although in general this process was not deemed a major problem.

Business Process Findings

The following are assessment findings for business processes in the Operations Management Area:

OM1 Service Authorization

Business processes related to prior authorization remain constrained by paper-driven, dated processes. Although 278 Prior Authorization Review Request and Response are available for use resulting in automated processing of a portion of service authorizations use is not widespread. However, web enabled prior authorization services have been implemented. Service Authorization Reviewer's remain limited to manual processes being required review cases while entering data from written, phone and fax requests into Indiana*AIM*. Electronic responses are not provided for 278 requests while oral responses are provided for telephone requests. Web enabled requests are available to providers for FFS and Care Select and responses are viewable via the web. The Format, content and PHI procedures for service authorizations are HIPAA compliant.

OM1 - Service Authorization – Authorize Referral

The Authorize Referral process is performed by the CMOs for FFS and MCO's for managed care members and providers, and Roeing for the waiver program all under vendor contracts. Referrals and Authorizations are manually processed for FFS. MCO's have some level of automation in the referral and authorizations with limited use of 278 transactions. Web Interchange allows submission of Authorizations over the web. All review and approval processes are manual. Roeing uses a tool called Insight for the waiver program which electronically submits referrals and authorizations electronically to Indiana*AIM* after manual approval. The Insight system is used to load PA for waiver programs by case managers. PAs are then loaded into the MMIS. The MMIS could support Waiver programs directly, but DDRS administers Waiver program using separate vendor.

The PA Authorize Referral process is not a centralized process for FFS and MCO's, but all must follow Indiana Administrative Code. There is no requirement that they use the same criteria for the PA process resulting in a lack of standardized business rules. Internal process varies by MCO or waiver provider.

Maintaining data and system changes are expensive to the vendors and MCO's who have risk based contracts, but not to the State, depending on the type of change that is required. If it is a system logic change, it can be expensive. If it is a maintenance change it is already included in the OMPP contract with EDS. Modifications to MMIS are billed against a MMIS modification pool of hours/money. For MCO's, the cost is included in the capitation fee.

While these Authorize Referral process capabilities result in overall assessment for this business process at a Maturity Level 1, this process does have some notable characteristics that achieve level 2 in areas of increased automation and activities that result in improved data access and accuracy. These characteristics include web enabled acceptance of Service Referrals and Authorizations via the Internet web portal. FFS is using a web portal to initiate the PA process for some programs, but the PA is not directly processed into the MMIS. MCO's on the other hand, do not have a web portal available to providers for the submission of PA or referrals.

The Authorize referral process in Indiana does not fully achieve Maturity Level 2 because of the intermittent use of automation by MCO's and because the Indiana*AIM* continues the practice of sending letters to providers requesting additional information if the PA request is incomplete rather than using 277 EDI transaction for the notice. Additionally, it was not affirmed if

the process for MCO's includes automated 277 transaction responses back to provider requesting additional information.

OM1 - Service Authorization – Authorize Service

The Authorize Service process is performed by the CMOs for FFS and MCO's for managed care members and providers, and Roeing for the waiver program all under vendor contracts. The capabilities for Authorize Service are virtually identical to those of Authorize Referral with further automation of processes. PA Requests can be initiated via Web-Interchange (e.g. providers can submit a 278 for request of a PA), however, while a variety of submission methods are offered, PA does not use other EDI, email, dialup, disks or tape for submission.

Like Authorize referral, maintaining data and system changes are expensive to the vendors and MCO's who have risk based contracts, but not to the State, depending on type of change that is required. If it is a system logic change, it can be expensive. If it is a maintenance change it is already included in the OMPP contract with EDS. Modifications to MMIS are billed against a MMIS Modification pool of hours/money. For MCO's, the cost is included in the capitation fee. Business Rules are not standardized.

Also like Authorize referral, Authorize Service does not fully achieve Maturity Level 2 because of the intermittent use of automation by MCO's and because the Indiana*AIM* continues the practice of sending letters to providers requesting additional information if the PA request is incomplete rather than using 277 EDI transaction for the notice.

OM1 - Service Authorization – Authorize Treatment Plan

This Authorize Treatment Plan process is performed by the CMOs for FFS and MCO's for managed care members and providers, and Roeing for the waiver program all under vendor contracts. The capability assessment for Authorize Treatment Plan duplicates those of Authorize Referral and Authorize Service. Although Treatment Plans are performed manually for all programs, the waiver service vendor, Roeing, has an automated tool for creation and receipt of treatment plans and all HCBS providers use Medicaid Standards.

Like Authorize referral and Authorize Service, maintaining data and system changes are expensive to the vendors and MCO's who have risk based contracts, but not to the State, depending on type of change that is required. If it is a system logic change, it can be expensive. If it is a maintenance change it is already included in OMPP contract with EDS. Modifications to MMIS are billed against a MMIS Modification pool of hours/money. For MCO's, the cost is included in the capitation fee. Business Rules are not standardized.

Authorize Treatment Plan does not fully achieve Maturity Level 2 because it does not use 277 transactions.

OM2 – Claims/Encounter Adjudication

Claims and Encounter adjudication processes, audits and edits, pricing and payment including retroactive payments are performed primarily through automated processes with exceptions and suspended claims requiring manual intervention. EDS uses electronic attachments, but MCO's are not yet using electronic attachments for claims adjudication. Real time processing is not available for electronic claims currently. Vendor costs for system maintenance remain high, but due to risk based contracts these costs are

low for the state. EDS sends HIPAA 835 transactions, but not 276 or 277 transactions. System modifications result in additional costs to the state; however, and, modifications are reduced, but have not been eliminated.

OM2 - Claims/Encounter Adjudication - Apply Claim Attachment

The Apply Claim Attachment process is performed by EDS for FFS claims and MCO's for the Managed Care program. Apply Claim Attachment processes in Indiana include both automated and manual processes, with electronic processes matching the attachment to claims in FFS, but must be manually attached by Provider for claims processing in the Managed Care program. Attachment review remains labor intensive due to the need for manual review of each attachment. EDS is meeting Agency goals for appropriateness of payment. Attachments stay with the claim in FFS as well as in the Managed Care program (MCO's). No inconsistencies were noted. Infrequently, there could be instances where attachments are misplaced. These capabilities establish Apply Claim Attachment process at Maturity Level 1.

Some capability characteristics to achieve level 2 were affirmed, although the process could not be fully assessed at this level. Capabilities such as the use of electronic attachments by FFS – (EDS uses them) would achieve level 2, but they not used by MCO's. If electronic attachments were used universally, this process would have more fully achieved level 2. Accuracy is improved and the State is in compliance with HIPAA standards, but staff has not been reduced as they are still required to work the claim. Some manual processes are being replaced by electronic processes and are producing better results and this automation is bringing better value to stakeholders.

OM2 - Claims/Encounter Adjudication - Apply Mass Adjustment

The Apply Mass Adjustment process is performed by EDS for FFS claims and MCO's for the Managed Care program. Apply Mass Adjustment process capabilities still require manual submission of requests, and although a large staff is not required, and an audit trail is present in the system, there are manual steps to request, and review. EDS is contacted to review data and data is displayed in spreadsheets after the mass adjustment has run. Mass Adjustment data cannot be accessed in Indiana*AIM*. For these reason the process is assessed at maturity Level 1.

Some characteristics of capabilities at level 2 were identified, but they were not sufficient to assess the entire process at level 2. These characteristics include improvement to operations that have reduced the number of requested mass adjustments, the identification of claims to be adjusted and application of the adjustment automated with audit trail resulting in increased value to stakeholders. However, lack of automated business rules for FFS or improvements in timeliness mean that this process does not fully achieve Maturity Level 2.

OM2 – Claims/Encounter Adjudication – Audit Claim/Encounter

The Audit Claim/Encounter process is performed by EDS for FFS claims and MCO's for the Managed Care program. While a high level of automation is used for the Audit Claim/Encounter process, capabilities are assessed at level 1 due to such characteristics as lack of improvements in timeliness, for Edits there is no lengthy resolution timeframe, but for Audits it can be lengthy. Data is not comparable among the siloed systems in use by the Enterprise. For FFS all claims go through the MMIS where attachments are automated, but for the MCO's additional documentation provided via paper can make it difficult to override the claim edits. Additionally, maintenance

(not modification) is expensive for the vendors. MMIS Modifications that may be required go against an annual pool of hours and can be expensive for the State if they are large enough.

On the other hand, attachments that are electronic are improving outcomes. Vendors are meeting agency requirements for timeliness and accuracy and certain other characteristics of Audit Claim/Encounter capabilities did achieve level 2. The electronic claim processing and POS adjudication are experiencing greater increases in timeliness and the number of small providers who can submit electronically is increasing. However, continued costliness of maintenance, the use of 835 rather than X12 276 transactions prevents this process from fully achieving Maturity Level 2.

OM2 – Claims/Encounter Adjudication – Edit Claim/Encounter

The Edit Claim/Encounter process is performed by EDS for FFS claims and MCO's for the Managed Care program. The capability characteristics for Edit Claim/Encounter mirror those of Audit Claim /Encounter with this process fully achieving Maturity Level 1 and possessing certain characteristics of capabilities at Maturity Level 2, such as use of structured data, and increased value to stakeholders, but not fully achieving this level for the same reasons as identified for Audit Claim/Encounter.

OM2 – Claims/Encounter Adjudication – Price Claim/Value Encounter

The Price Claim/Value Encounter process is performed by EDS for FFS claims and MCO's for the Managed Care program. Price Claim/Value Encounter capabilities do fully achieve Maturity Level 2 with all capability characteristics affirmed. All programs use the Indiana Medicaid Fee Schedule and pricing formulas are agency specific. Automated processing of single claim

adjustments does occur; however, requests must be entered manually. Webinterchange provides completely automated processes for such adjustments.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because automated business rules allow for reduced time to implement changes. This process cannot be fully assessed at level 3 because certain capabilities including use of MITA standard interfaces, immediate electronic responses, highly flexible business rules allowing rules and code set changes to be made quickly and inexpensively, flexibility in changing pricing algorithms, and coordination with sister agencies and waiver programs to present a one-stop shop claim adjudication and pricing process have not yet been achieved.

OM3 - Payment and Reporting

Business process capabilities for Payment and Reporting generally include a combination of automated and manual processes. Provider payments made through EDS are largely made through EFT. MCO payments to providers are not as fully automated including the issuance and mailing of paper checks and processes for accounting for payments. Reporting processes are largely automated allowing for user definition of reports. Providers can choose paper or electronic RA regardless of billing method. Electronic 835 Remittance Advice (RA) is widely used by EDS, but must be requested. Continued use of paper RA's by MCO's and non-electronic billers who automatically receive a paper RA, requires manual processes. Changes to the process would be expensive and time consuming to move to more of a COB model, currently claims are denied where a primary payer has been identified and the provider must resubmit to that payer. The Business

Processes for Prepare Premium EFT/Check, Prepare Provider EFT/Check, Prepare Remittance Advice/Encounter Report, have fully achieved Maturity Level 2 with only Prepare Premium EFT/Check achieving some measure of Maturity Level 3.

OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)

The Prepare Coordination of Benefits (COB) process is performed by HMS under subcontract to EDS and the MCO's for the Managed Care program. While this process was assessed at level 1, Prepare COB does possess most, though not all, of the characteristics of capabilities that achieve Maturity Level 2 but could not be fully assessed at this level. The "Prepare COB" process capabilities are largely automated. For FFS "by report" pricing is an automated process in Indiana*AIM* and MCO's can create bonus payments in an automated manner as well. Post payment recovery (Pay and Chase) claims which are submitted to third party payers are largely automated.

The single capability limiting this process from achieving level 2 is that while Indiana does cost avoid, cost avoided claims are not sent to primary payers. Denials are sent to the provider to resubmit to the primary payer. At level 2 some claims are sent on to the primary payer and the capabilities required to perform this are not yet in place.

However additionally, certain capability characteristics for this process have achieved Maturity Level 3 because the agency staff is now free to focus on strategic perspectives because operations are automated and accurate. This process cannot be fully assessed at level 3 because it has not fully achieved level 2 and capabilities necessary for post payment recovery processing that is highly flexible supporting complex algorithms so that rules and code set changes can be made quickly and inexpensively. Also, automated business

rules, post payment recovery (Pay and Chase) claims submission to third party payers using MITA national standards, automated flagging of post payment recovery claims, use MITA standard interfaces, use of manual intervention only in rare circumstances, and forwarding to primary payers have not yet been achieved.

OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)

The Prepare Explanation of Benefits (EOB) process is performed by EDS for FFS claims and MCO's for the Managed Care program. The "Prepare EOB" process capabilities are fully described to achieve level 1. EOMBs are generated by EDS for the FFS plan, however, it was not clear how MCO's facilitate this process. Letters are generated and mailed to members by EDS on a monthly basis, and members return the results to EDS. EOMBs issued are selected via sampling and not all members receive them. Sensitive services are suppressed in the sampling process. The EOMB standard meets federal regulations. Large staff is not required for this process as it is largely automated and the program is integrated. Members are asked to read, review and report discrepancies. Payments and provider types are standard.

The only capability possessed at level 2 for this process was timeliness of process due automation. EDS uses an automated random sampling process to select the members to receive an EOMB. It is a mix of automated and manual processes. However, enhanced sampling process to target selected populations is not available, member responses must be manually tabulated, staff has not been reduced and cultural and linguistic adaptations have not been introduced.

OM3 - Payment and Reporting - Prepare Home and Community-Based Services (HCBS) Payment

The Prepare Home and Community-Based Services (HCBS) Payment process is performed by EDS for FFS claims and MCO's for the Managed Care program. Prepare HCBS payment capabilities do fully achieve Maturity Level 2 with all capability characteristics affirmed. A mix of automated and manual processes is used, reducing the time required. The Medicaid agency works with all HCBS programs to share Medicaid processes and all HCBS programs use Medicaid business processes for service authorization and service payment. Automation reduces staff required and accuracy of results is improved. HCBS providers agree to use Medicaid standards for prior authorization and claims adjudication and payment

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because the majority of processes are automated and paper checks are rarely used. This process can not be fully assessed at level 3 because capabilities including MITA Standard Interfaces and immediate response times have not yet been achieved.

OM3 - Payment and Reporting - Prepare Premium EFT/Check

The Prepare Premium EFT/Check process is performed by EDS for FFS claims and MCO's for the Managed Care program. Prepare Premium EFT/Check capabilities also fully achieve Maturity Level 2 with all capability characteristics affirmed. Both EDS and MCO's use Electronic Funds Transfer (EFT), reducing turnaround time. Transactions comply with state or industry standards for EFT transactions and conform with HIPAA transaction standards where appropriate. Billers are encouraged to bill electronically and staff time has been almost eliminated as more billers have adopted

receiving payment via EFT payments. Increased volume of EFT payments and automation has increased accuracy of the process and stakeholder satisfaction is improved.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because the majority of processes are automated, electronic interfaces are used and paper checks are rarely used. This process can not be fully assessed at level 3 because capabilities including MITA Standard Interfaces, shared processes and inter-agency collaboration, intra and inter-state collaboration, and immediate response times have not yet been achieved.

OM3 - Payment and Reporting - Prepare Provider EFT/Check

The Prepare Provider EFT/Check process is performed by EDS for FFS claims and MCO's for the Managed Care program. Like the "Prepare HCBS" and "Prepare Premium EFT/Check" processes, "Prepare Provider EFT/Check" capabilities also fully achieve Maturity Level 2 with all capability characteristics affirmed. Both EDS and MCO's use EFT, reducing turnaround time. Transactions comply with state or industry standards for EFT transactions and conform with HIPAA transaction standards where appropriate. Billers are encouraged to bill electronically and staff time been almost eliminated as more billers adopt EFT payments. Increased volume of EFT payments and automation has increased accuracy of the process. The process is standardized and is not siloed.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because paper checks are rarely used for FFS payments. This process can not be fully assessed at level 3 because capabilities including MITA Standard Interfaces, shared processes and inter-agency

collaboration, intra and inter-state collaboration, and immediate response times have not yet been achieved.

OM3 - Payment and Reporting - Prepare Remittance Advice/Encounter Report

The "Prepare Remittance Advice/Encounter Report" process is performed by EDS for FFS claims and MCO's for the Managed Care program. "Prepare Remittance Advice/Encounter Report" capabilities also fully achieve Maturity Level 2 with all characteristics of capabilities affirmed at this level. For this process EDS complies with HIPAA to supply an electronic RA that meets state agency Implementation Guide requirements. Providers can choose paper or electronic RA regardless of billing method. An 835 transaction must be requested and non-electronic billers automatically get a paper RA. These are exceptions; however, the process largely uses electronic RA's. Capitation payments are automatically produced based on state-specific business rules with state approval utilizing HIPAA standards for electronic premium payments. With automation of the process results are improved and less staff is needed. Utilization of HIPAA transactions improve accuracy of results of business processes in terms of standardized processing of capitation to all MCO's. The increase in automated processing allows the agency to focus on cost management and automated capitation premium payments bring added value to the stakeholders.

OM4 - Capitation and Premium Preparation

Business process capabilities for Capitation and Premium Preparation including capitated payments, health insurance premiums and Medicare premiums generally include a combination of automated and manual processes. Capitation payment processes are largely automated and utilize

HIPAA transactions and achieve Maturity Level 2. Payment calculations are automated as is generation of reports. Premium preparations require some manual intervention and processing, achieving Maturity Level 1.

OM4 – Capitation and Premium Preparation – Prepare Capitation Premium Payment

The Prepare Capitation Premium Payment process is performed by EDS for FFS claims and MCO's for the Managed Care program. Prepare Capitation Premium Payment was assessed to have fully achieved maturity at level 2. While much of the process is automated and capitation premium payments are generated and distributed utilizing HIPAA compliant electronic payment transactions, only authorized operations staff can access Capitation Premium data and requests for information must go through these staff. Capitation premium data are more standardized through the use of HIPAA compliant transactions. Capitation payments are automatically produced based on state-specific business rules that are approved by the state utilizing HIPAA standards for electronic premium payments. Automation has improved results and less staff is needed. The increase in automated processing allows the agency to focus on cost management. The automated capitation premium payments bring added value to the stakeholders

OM4 – Capitation and Premium Preparation – Prepare Health Insurance Premium Payment

The Prepare Health Insurance Premium Payment process is performed by EDS for HIPP participants. Prepare Health Insurance Premium Payment process capabilities are assessed at Maturity Level 1. At this time, there are only 3 members on the HIPP program and thus the process does not require a large staff or time to perform, but processes remain largely manual because there

are so few members enrolled in the program, thus automation may not be cost effective at this point in time. The process is standardized, although it continues to be siloed and manual. Screening is done by an eligibility determination vendor and is primarily a manual process. A form is manually completed and sent to EDS to determine if the member is eligible for HIPP. Premiums are paid to the member and not to the insurance company at this point. EDS interacts with the employer and employee to process the payment and not with the insurance company.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because standardized data is used for this process.

OM4 – Capitation and Premium Preparation – Prepare Medicare Premium Payment

The Prepare Medicare Premium Payment process is currently performed by EDS. As identified in the Medicare Buy-In Operating Procedures Manual the agency does exchange information with the SSA using electronic communication standards specified by SSA. Members who meet criteria for buy-in to Medicare Part B are identified by EDS and the Medicare Part B premium buy-in report is prepared. Premiums are prepared according to the Medicare requirements. The Prepare Medicare Premium Payment capabilities are assessed based on the documentation available at Maturity Level 1 in terms of Data Access and Accuracy, Effort to Perform/Efficiency, Cost-Effectiveness and Accuracy of Process Results.

The only capability possessed at level 2 for this process was Effort to Perform/Efficiency because business rules are used to improve identification of buy-in candidates, prepare the premium payment calculation, and track the data exchange.

OM5 – Payment Information

Business process capabilities for Payment Information, Inquire Payment Status and Manage Payment Information, include a combination of automated and manual processes that is primarily automated. While web services are available, phone inquiries appear to require human intervention. Inquire Payment Status and Manage Payment Information processes fully achieve Maturity Level 2. Manage Payment Information business processes are largely automated as are SURs and MARs reporting.

OM5 – Payment Information Management – Inquire Payment Status

The Inquire Payment Status process is performed by EDS for FFS claims and MCO's for the Managed Care program. The Inquire Payment Status process capabilities are assessed to be fully capable at Maturity Level 2. Web services are available for payment inquiries made to EDS, EDS also has AVR, which is also available through all MCO's, however not all MCO's have web services for inquire payment status. Payment status inquiry data uses agency standards and EDS and MCO's complete payment status inquiries within the contractual requirements. The increased utilization of electronic transactions continues to increase cost efficiency, allowing the Agency to focus on cost management and increases stakeholder satisfaction.

OM5 – Payment Information Management – Manage Payment Information

The Manage Payment Information process is performed by EDS for FFS claims and MCO's for the Managed Care program. The Manage Payment

Information process capabilities are assessed to be fully capable at Maturity Level 2. Business rules are primarily supported by automated processes in management of payment information and are supported by electronic interchange such as EDI, POS and Web portals with increased electronic payments. The Agency now has improved ability to compare data across programs. HIPAA compliant transactions have standardized payment information management. All of these capabilities increase cost efficiency, improve accuracy and bring greater value to stakeholders.

OM6 – Member Payment Management

Member Payment Management business processes include Calculate Spend-Down Amount and Prepare Member Premium Invoice. Both of these processes fully achieve capability Maturity Level 2. Calculate Spend-Down Amount is largely automated with manual processes used for update and validation exceptions. Member Payment Management utilizes a combination of manual and automated processes. Member invoicing is largely automated with payment processes, use of lock box and accounting requiring manual processes. Increased use of automated payment and accounting processes, reporting and business rules will further improve Timeliness, Data Access and Accuracy, Effort to Perform and Efficiency, Cost-Effectiveness, Accuracy of Process Results or Utility or Value to Stakeholders.

OM6 – Member Payment Management – Calculate Spend-Down Amount

The Calculate Spend-Down Amount process is performed by EDS under a vendor contract for these services. The Calculate Spend-Down Amount process capabilities are assessed to be fully capable at Maturity Level 2. Use of relational databases improves data access and accuracy, with member updates and data extractions improving timeliness. Electronic reporting

captures out of pocket expenditures. EDS performs a monthly reconciliation for spend down claims. Automatic updates have resulted in the need for less staff. Automated maintenance of member information ensures that timely, accurate data are available to support all processes.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 including immediate updates by EDS when updating the claims and use of standardized letters. This process does not fully achieve level 3 maturity because other capability characteristics such as the use of a single Member Registry or federated Member Registries that can be accessed by all authorized applications, further reductions in staff, automated data distributions to data sharing partners and algorithmically associated member data to support federated access, automated updates, reconciliation and extraction of complete and quality data have not yet been achieved.

OM6 - Member Payment Management - Prepare Member Premium Invoice

The Prepare Member Premium Invoice process is performed by EDS under a vendor contract for these services. The Prepare Member Premium Invoice process capabilities are assessed to be fully capable at Maturity Level 2. Automated solutions are used for this process. Premium invoices are supported by program specific accounting modules that maintain a detailed transaction history of all monies received from members. Current balances and transaction history is stored for online viewing. Efficiency is increased by maintaining a detailed history of all monies received from members. A Payment record is generated. Online access to information improves accuracy and stakeholder satisfaction.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 including a centralized member accounting system

associated with the Member Registry that can be used to establish the amount of the member liability and member liability amounts can be updated by MMIS with online adjustment capability. The process does not fully achieve Maturity Level 3 because capabilities for the use of centralized member accounting modules on the MMIS that communicate with Agency financial systems and flexibility in accepting payments at all Agency sites have not yet been achieved.

OM7 – Cost Recoveries

Business process capabilities for Cost Recoveries generally include a combination of automated and manual processes; more or less automation is utilized depending on the Capability. The overall drug rebate process follows the uniform rules prescribed by CMS for Drug Rebate programs. Drug Rebate is automated through data tape exchange with CMS and labeler invoicing. Payments lock box and accounting procedures require manual paper based processes and disputes, as do supplemental rebate bid processes. Drug Rebate achieves Maturity Level 2. Manage Estate Recovery, Manage Recoupment, and Manage Settlement processes remain dependent on manual processing. Recoupments are increasing use of EDI and automated processes. Manage Recoupment achieves some measure of capability Maturity Level 3. Manage TPL Recovery processes are largely automated with electronic eligibility data exchange between EDS and MCO's, direct billing and automated invoicing procedures, fully achieving capability Maturity Level 2 for all characteristics; however, payment receipt, lock box and accounting activities remain primarily manual processes.

OM7 – Cost Recoveries – Manage Drug Rebate

The Drug Rebate process is performed by ACS under a vendor contract. This process is largely automated and the process capabilities are assessed to be fully capable at Maturity Level 2. The process uses use electronic interchange and automated processes. Data are standardized and automation uses centralized processes resulting improved comparability of data. This standardization of data is also increasing rebates. Centralization of drug utilization data from siloed programs is improving coordination of processes, achieving economies of scale and improving rule application consistency. The electronic interchange and automated processes that are used have increased stakeholder satisfaction with quicker response times to inquiries and report requests.

Additionally, most capability characteristics for this process have achieved Maturity Level 3 due to automation of the processes resulting in increased cost efficiency and accuracy as well as consistent and timely communications, use of standardized data and automated electronic interchanges (interfaces) between agencies and drug manufacturers, and support for data and technology integration and interoperability. The process does not fully achieve Maturity Level 3 because capabilities using MITA standard interfaces have not yet been achieved.

OM7 - Cost Recoveries - Manage Estate Recovery

The Manage Estate Recovery process is performed by OMPP. This process is performed using a combination of manual and automated processes, many processes remain manual and for this reason the process is fully assessed to achieve Maturity Level 1. For internal record keeping, an internal ACCESS database is used to maintain information. Currently, IT staff is needed to load member information generated from other systems, while a Court

Docket system is in the process of being automated; it is not yet in use. Currently half of the state is on the automated system, OMPP is not yet. The data warehouse (DW) is matched to the Docket system for those that are using the system. A Cognos file is created with a list of all deceased members at the Department of Health (DOH) and their known resources. The process is not focused on compliance with agency requirements or on ensuring timely availability of quality/complete data for users. There is a problem accessing this information by OMPP staff that exists within the claims management area. Updates and reconciliations are validated by claims management. Member information is not maintained and available on a scheduled or on-request basis to other business processes and users. DW data is provided on a scheduled basis but this information is not shared with other business users. The Manage Estate Recovery process capabilities are assessed to be fully capable at Maturity Level 1. No characteristics of capabilities exceeded level 1 to achieve level 2.

OM7 - Cost Recoveries - Manage Recoupment

The Manage Recoupment process is performed by EDS under vendor contract. The Manage Recoupment process capabilities are assessed to be fully capable at Maturity Level 1. This process is currently completed with an increased use of electronic interchange and automated processes with business rules supported by some automated processing. Recoupment data are more standardized through the use of HIPAA compliant transactions improving usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis and increasing cost efficiency. Increased automation is producing improved results, allowing the Agency to focus on cost management, and brings greater value to stakeholders.

This process also achieves a high level of maturity for most capability characteristics at level 2 with the exception of the use of HIPAA 837 transactions (which is not currently used) from payer to payer used at least in part by the Agency limiting this process from fully achieving maturity at level 2.

Additionally, certain capability characteristics for this process have achieved Maturity Level 3 because a majority of the processes are automated. The process does not fully achieve Maturity Level 3 because capabilities using MITA standard interfaces and inter and intra state collaboration and health information exchange have not yet been achieved.

OM7 - Cost Recoveries - Manage Settlement

The Manage Settlement process is performed by HMS under subcontract to EDS. The Manage Settlement process capabilities are assessed to be fully capable at Maturity Level 1. Year end cost settlements are computed for some providers including state operated nursing home and ICFs/MR. FQHCs and RHCs are paid a PPS rate and receive the difference between their PPS rate and amounts paid by managed care organizations, with a year-end settlement. Nursing home, group home and home health agency cost reports are subjected to desk review for rate setting purposes and audits for program compliance purposes, variances are reflected in adjusted rates, both retroactively and prospectively.

OM7 - Cost Recoveries - Manage TPL Recovery

The Manage TPL Recovery process is performed by HMS under subcontract to EDS. The Manage TPL Recovery process capabilities are assessed to be fully capable at Maturity Level 2. Manage TPL Recovery processes are largely

automated with electronic eligibility data exchange between EDS and MCO's, direct TPL billing and automated invoicing procedures. A Bendex file also provides information. Payment receipt, lock box and accounting activities are performed using FirstThird Bank and remain primarily manual processes. Utilization of electronic transactions is increasing cost efficiency and results have improved. Automation has improved accuracy and allows the agency to focus on cost management.

3.4.4 Strengths and Weaknesses for Current Business Processes

Strengths in Current Business Processes

Key strengths of the current Operations Management business processes include:

- Accuracy of the service authorization process through increasing use of electronic transactions
- Data Access and Accuracy through the use of web based prior authorization services
- HIPAA compliance and companion guides are published and in use by the provider community
- Increased managed care enrollment reduces FFS claims processing requirements and the use of attachments where capitated payments are made.

- Electronic data improves timeliness and reduction of requests for mass adjustments
- Electronic claim processing and POS adjudication increase timeliness of edits and audits reduces claim pending and suspension. Other Level 2 achievements for improved processes for edits and audits included use of HIPAA compliant data – use of X12 276.
- Automated business rules for claims pricing and encounter valuation achieve Maturity Level 3.
- HCBS programs use Medicaid business processes for service authorization and service payment
- Use of state or industry standards for EFT transactions and conformation with HIPAA transaction standards bring increased value to stakeholders
- Both EDS and MCO's use EFT
- Processes are standardized, but are not siloed
- Automation of payments and reporting allow the Agency to focus on cost management
- Providers can choose paper or electronic RA regardless of billing method
- For Premium Preparation, use of business rules to improve identification of buy-in candidates, prepare the premium payment calculation, and track the data exchange.

- A majority of Payment information processes are automated, providing increased utility to stakeholders.
- Use of electronic interchange and automated processes in the Cost Recoveries Business processes.
- Standardized and automation centralized processes in the Cost Recoveries business processes improve comparability.
- Centralizing drug utilization data to achieve increased coordination, achieve economies of scale, and to improve rule application consistency
- Cost Recoveries Business rules are increasingly supported by some automated processing.

Weaknesses in Current Business Processes

The following weaknesses were noted in the current Operations Management Business Area:

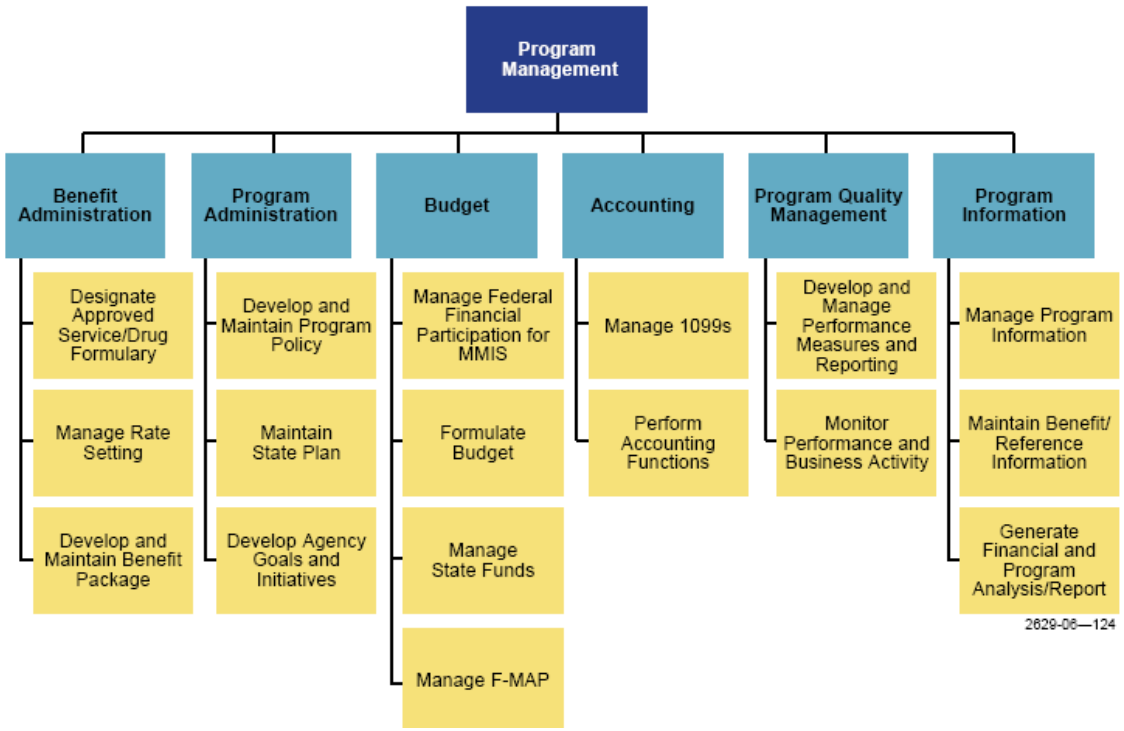
- Low use of standard reports that run automatically in the payment and reporting area.
- For Member Payment Information, Member invoicing is largely automated, however the accounting piece associated with this process is manual in nature.
- Increased use of electronic invoicing, billing, payments, automated reporting and electronic data exchange in the drug rebate processes will improve Timeliness, Data Access and Accuracy, Effort to Perform

and Efficiency, Cost-Effectiveness, Accuracy of Process Results or Utility or Value to Stakeholders.

- Claims processing can be improved with the introduction of real-time electronic claims processing submitted via Webinterchange, which should improve the timeliness, efficiency, effectiveness and accuracy of claims payment.

3.5 Program Management

3.5.1 Business Area and Business Process Description



The Program Management business area houses the strategic planning, policy making, monitoring, and oversight activities of the agency. These activities depend heavily on access to timely and accurate data and the use of analytical tools. This business area uses a specific set of data (e.g., information about the benefit plans covered, services rendered, expenditures, performance outcomes, and goals and objectives) and contains business processes that have a common purpose (e.g., managing the Medicaid program to achieve the agency's goals and objectives such as by meeting budget objectives, improving customer satisfaction, and improving quality and health outcomes).

This business area includes a wide range of planning, analysis, and decision-making activities, including benefit plan design, rate setting, healthcare outcome targets, and cost-management decisions. It also contains budget analysis, accounting, quality assessment, performance analysis, outcome analysis, continuity of operations plan, and information management.

This is the heart of the Medicaid enterprise and the control center for all operations. As the Medicaid enterprise matures, Program Management benefits from immediate access to information, addition of clinical records, use of standards, and interoperability with other programs. The Medicaid program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.

3.5.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Accounting – Manage 1099s	The Manage 1099s business process describes the process by which 1099s are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number.The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process. The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.	1
Accounting – Perform Accounting Functions	The Perform Accounting Functions business process receives information from payment processes such as Prepare Provider EFT/Check, Prepare Premium EFT/Check and Prepare Member Premium Invoice. It also receives information financial recovery processes such as Manage Recoupment, Manage TPL Recovery, Manage Estate Recovery and Manage Drug Rebate. Currently States use a variety of solutions including outsourcing to another Department or use of a	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	COTS package.	
Benefit Administration – Designate Approved Services/Drug Formulary	The Designate Approved Services/Drug Formulary business process begins with a review of new and/or modified service codes or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.Service, supply and drug codes are reviewed by a team of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.NOTE: This does not include implementation of Approved Service/Formulary.	2
Benefit Administration – Develop and Maintain Benefit	The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from	2

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Package	external parties such as quality review organizations or changes resulting from court decisions. Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including: - Determination of scope of coverage - Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. - Identification of impacted members and trading partners.	
Benefit Administration – Manage Rate Setting	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program	1
Budget – Formulate Budget	The Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	periodically produces a new budget.	
Budget – Manage Federal Financial Participation for MMIS	The Federal government allows funding for the design, development, maintenance and operation of a federally certified MMIS. The Manage Federal Financial Participation business process oversees reporting and monitoring of Advanced Planning Documents and other program documents necessary to secure and maintain federal financial participation. These are the types of functions within this business area but this does not appear to be a stand-alone process.	1
Budget – Manage Federal Medical Assistance Percentages (F-MAP)	The Manage F-MAP business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.	2
Budget – Manage State Funds	The Manage State Funds business process oversees Medicaid state funds and ensures accuracy in reporting of funding sources. Funding sources for Medicaid services may come from a variety of sources and often State funds are spread across administrations. The Manage State Funds monitors state funds through ongoing tracking and reporting of expenditures.These are the types of functions that may occur within this business area, but this does not appear to be a stand-alone process.	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Program Administration – Develop Agency Goals and Initiatives	The Develop Agency Goals and Initiatives business process periodically assess current mission statement, goals, and objectives to determine if changes are called for. Changes to goals and objectives could be warranted under a new administration or in response to changes in demographics or public opinion; or in response to natural disasters such as Katrina.	1
Program Administration – Develop and Maintain Program Policy	The Develop and Program Administrative Policy Business Process responds to requests or needs for change in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer pressure.	1
Program Administration – Maintain State Plan	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	1
Program Information – Generate Financial & Program Analysis/Report	It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to theintent of the legislative laws or Federal reporting requirements.The Generate Financial &	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	Program Analysis/Report process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), retrieving data from multiple sources, e.g., Manage Payment History; Maintain Member Information; Manage Provider Information; and Maintain Benefits/Reference Repository; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.	
Program Information – Maintain Benefit/Reference Information	The Maintain Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter or Price Claim/Encounter. It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new HCPCS, CPT and/or Revenue codes, adding rates associated with those	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction.	
Program Information – Manage Program Information	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions.The Program Information Repository receives requests to add, delete, or change data in program records. The Repository validates data upload requests, applies instructions, and tracks activity.The Program Information Repository provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, via batch record transfers, response to queries, and “publish and subscribe”	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
	services.	
Program Quality Management – *Develop and Manage Performance Measures and Reporting*	The Develop and Manage Performance Measures and Reporting business process oversees reporting and monitoring of Medicaid Enterprise to assure that the program meets the statutory requirements of the program. Performance Measures and Reporting requirements are continually assessed and respond to changes in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer pressure.	1
Program Quality Management – *Monitor Performance and Business Activity*	The Monitor Performance and Business Activity business process utilizes the performance measures from the Develop and Manage Performance and Reporting business process to oversee efficacy of the Medicaid Enterprise. For example, this process provides the indicators of underserved populations to support member outreach activities and ensures that applicants and members receive the information they need. This process may send prompts to the provider or contractor processes to reevaluate enrollment, to disenroll a provider or contractor to or oversee the outreach activities. This process also detects utilization outliers and alerts applicable claims processes.	1

3.5.3 Capability Maturity Findings

The Program Management area business processes are performed through a combination of both manual and automated processes. Several business processes are conducted via a combination of paper-based process and tracking combined with automated processes using EDI processing through Indiana*AIM* or PeopleSoft solution.

The strategic plan and program goals were designed to provide the strategic vision for the Medicaid enterprise. Tracking and reporting of performance on these goals has been difficult to clearly ascertain, since it has been given limited transparency. It appears Indiana FSSA has been striving to increase its usage of automated solutions within the last five years to improve interoperability across the Medicaid Enterprise. Most of the business processes relating to cost management and federal cost reporting and analysis have been centralized within the FSSA Financial Management division. Implementing the PeopleSoft Financial Module has improved timeliness and accuracy of budgeting, federal claiming, and program cost data monitoring and reporting.

Provider Association Focus Group Comments

The Provider Association made clear recommendations that OMPP needs to improve the transparency of Medicaid program information. Specifically,

providers indicated interest in information on overall program costs and service costs by provider type. The Provider Association group felt that an enterprise-wide view of information would be most beneficial, and that they strongly supported policy direction for e-reports. They described frustration with storing data and reports in e-formats only to have to print paper copies all documents for State reviews and audits. Often information shredded and trashed following the review, since e-storage and access is easier and more cost effective.

Business Process Findings

The following are the assessment findings for business processes in Program Management.

Accounting - Manage 1099s

The Manage 1099s business process uses a combination of mostly automated processes with some manual operations. Provider 1099 reports are generated by EDS through the Indiana*AIM* system. This system tracks expenditures for each provider and posts total expenditures for the year to year-end Form 1099. Some data from payments received and/or recoupments are standardized and enable multiple 1099s to be generated. However, managing the 1099 process is not standardized across the Medicaid Enterprise. Edits and adjustments to the 1099s may use automated and some manual processing. Indiana*AIM* maintains control over accountability for all disbursements. Using Indiana*AIM* increases cost efficiency and access to provider information. OMPP reported that they only use a few staff to support the Manage 1099s business process to analyze

and make reconciliations. MCOs as well as the FSSA divisions (e.g., Aging) have a separate process for managing 1099s.

The Manage 1099s process was assessed at MITA Maturity Level 1 due to the timeliness, efficiency and effectiveness of the current process. Although, some characteristics could be affirmed at MITA capability maturity levels 2 and 3, there was not sufficient evidence that the complete maturity level had be achieve. While the some processes were completed with the support of electronic interchange to increase the efficiency and accuracy of results, other key areas of the process relied on manual, time consuming or disconnected processes, which prevented this process from achieving a higher level of capability maturity.

Accounting – Perform Accounting Functions

The Perform Accounting Functions business process operates with a combination of manual and automated operations. Accounting staff receive various check logs, deposit logs, cash control balances, and TPL recovery data electronically through Indiana*AIM* claims processing and other interchange systems. However, the complete CMS-64 function does require some manual operations. Indiana does not have a large staffing unit to manage the Perform Accounting Functions processes, and timeliness be impacted. Medicaid has manual processes for reporting and cost analysis. Accounting reports are generated from each FSSA program that administers Medicaid funds, including DA, DDRS, and DMHA which serve as the basis for manual accounting functions and processes. The data processed through Indiana*AIM* is HIPAA compliant, yet the program feels that HIPAA transactions do not increase the efficiency or effectiveness for the Enterprise.

FSSA and OMPP accounting staff are integrating cash management, federal funding, and general accounting functions through the PeopleSoft system. Automating processes has brought added value to the stakeholders, decreased processing time and increased accuracy within required timeframes.

For these reasons, the current state of the Perform Accounting Functions process was assessed at a MITA Maturity Level 1.

Benefit Administration – Designate Approved Services/Drug Formulary

Much of the Designate Approved Services/Drug Formulary business process is automated. However, the process also includes manual processes, such as policy and board review decision making functions. OMPP staff reported during the Validation Sessions that drug formulary reviews are based first on clinical data, then cost data. Various electronic systems and interfaces exist between the data warehouses and Indiana*AIM* to support this business process.

Certain drugs may be included or excluded for certain Medicaid programs. When changes or modifications are needed based on state or federal regulation or benefit services, drug codes can be easily updated electronically.

Since this process is primarily an automated clinically driven process the Designate Approved Services/Drug Formulary business process was assessed at MITA Maturity Level 2. Additionally, one characteristic in the Approved Services/Drug Formulary process relating to utilizing standardized data was affirmed at MITA Maturity Level 3.

Benefit Administration – Develop and Maintain Benefit Package

The Develop and Maintain Benefit Package business process uses mostly manual processes. Benefit Package requirements are established by assessing state and federal regulations and member benefit needs. Benefit Packages are created manually for each program through a variety of meetings, discussions and policy and procedure development steps. Within the last year, OMPP and FSSA have developed new benefit packages such as Care Select and Healthy Indiana Plan (HIP) programs. The HIP program was introduced as a consumer driven plan that incorporates personal responsibility for the member.

Members, providers, contractors, health plans, and other stakeholders can access consistent Benefit Packages information about programs, eligibility, services or providers via websites, policy or operating manuals, electronic newsletters or bulletins. State and program vendors also use electronic communications such as emails, benefit bulletins and various newsletters to maintain benefit package information to members and providers. Centralization of reference information increases consistency of communications and competency appropriateness of program and benefit information.

In Indiana, members are eligible for one benefit package at a time based on the active eligibility span as reported in the MMIS. Editing and auditing Benefit Package data in the MMIS system, Indiana*AIM*, can be electronically uploaded to assist with timeliness and accuracy. OMPP continues to make revisions and updates to benefit packages as needed.

The Develop and Maintain Benefit Package business process was assessed at MITA Maturity level 2, as all characteristics were achieved.

Benefit Administration – Manage Rate Setting

Indiana uses a combination of manual and electronic business processes to conduct the Manage Rate Setting process. OMPP contracts with Myers and Stauffer, a certified public accounting firm, to calculate, establish, and manage the Medicaid rate setting process. Standardized cost reports, such as the Indiana Medicaid Nursing Facility Financial Report, are used to calculate rates, including Long Term Care rates. Hard copy cost allocation reports are mailed hard copy or emailed to be uploaded electronically to vendor Myers & Stauffer to assist in establishing rates. Due to underutilization, cost reports are no longer uploaded to their website. Once rates are calculated, rate notifications are distributed to applicable entities through manual and electronic mail and available electronically from their website (www.mslcindy.com). The rate setting process can be time consuming and costly considering the amount of financial information needed to process to establish a rate. Some standardization has improved reporting processes, but many processes are manual.

FSSA Divisions (e.g., Aging) each have their own rate setting processes.

Manage Rate Setting was assessed at MITA Maturity level 1, as not all of MITA Maturity Level 2 was reached.

Budget – Formulate Budget

The Formulate Budget business process uses mostly manual procedures. FSSA and OMPP Financial Management staff utilize budget information from multiple, soloed programs administered by FSSA divisions to formulate the budget. Budgets and forecasts are created using Excel spreadsheets that pull information on Medicaid programs from across the Enterprise. Although the FSSA Financial Management has implemented the PeopleSoft Financial Module allowing them to electronically generate and query reports, the budget preparation, adjustment and approval processes remain largely manual processes. Based on documentation, several budgeting processes do not appear to have clearly documented parameters or timelines for the development, monitoring or reporting processes for program or enterprise budgeting. FSSA Financial Management staff reported that they are drafting an Accounts Procedures Guide to provide direction and assistance for many of these Program Management business process. A procedures guide could assist in improving budgeting business process management and efficiencies.

For these reasons, we assessed the Formulate Budget process at a MITA Maturity Level 1. We were able to affirm few Maturity Level 2 and 3 characteristics.

Budget – Manage Federal Financial Participation for MMIS

Managing Federal Financial Participation (FFP) for MMIS is mostly an electronic and automated process with some manual intervention. During the Validation Sessions, OMPP and FSSA Financial Management staff

explained how the PeopleSoft Financial Module assists staff with cost analysis and generation of federal FFP reports. However, the FFP reports for CMS still require some manual adjustments and reconciliations. Timeliness of reporting has also improved since Indiana began using the PeopleSoft solution. Indiana has not historically maximized enhanced federal funding for services being provided, including reimbursement for MMIS. To address some of the current limitations, FSSA is in the process of creating a Federal Funding Unit to manage and support all functions related to federal reporting.

Based on these conditions, the Manage FFP for MMIS business process was assessed at MITA Maturity Level 1. Although some characteristics could be affirmed at MITA Maturity Level 2, including use automated functions and staff size, this overall maturity level was not achieved as the current process is not currently managed at the enterprise level and manual processes are still key to reconciling reports.

Budget – Manage Federal Medical Assistance Percentages (F-MAP)

Managing Federal Medical Assistance Percentages (F-MAP) primarily uses electronic and automated business processes through use of the FSSA Financial Management PeopleSoft Financial Module application. During the Validation Session, staff provided a description of the Manage F-MAP business processes. There is little documentation that outlines F-MAP policy, procedure and process. However, Indiana is in the process of developing an Accounting Procedures Guide to document processes and reporting functions of the PeopleSoft application.

F-MAP rates are calculated electronically through the PeopleSoft Financial module queried reports. With this implementation, managing F-MAP procedures have been less labor-intensive to generate F-MAP percentages. Some staff and manual processes are required for adjusting F-MAP rates from previous years or those rates outside of normal business processes. Checks and balances of the Manage F-MAP percentage process use manual and electronic methods. The PeopleSoft Financial Module now calculates and generates the federal CMS F-MAP return instead of manually entering data elements. Timeliness of publishing rate notifications has improved with notifications due annually the first of October of each year.

The Manage Federal Medical Assistance Percentages (F-MAP) business process achieved 100% MITA capability maturity level 2 with a few characteristics assessed at a MITA Maturity Level 3.

Budget - Manage State Funds

The Manage State Funds business process is conducted by FSSA Financial Management on behalf of the Indiana Medicaid Enterprise. Information about Managing State Funds was provided through Validation Session discussion. Documentation detailing the process was not provided for review. A new FSSA Financial Management Accounting Procedures Guide is being developed to document standardized processes for managing FSSA state and federal funds. Funding sources for Medicaid services may come from a variety of sources and are often carried over from year to year, thus the need for electronic interchanges. Timeliness of analysis and reporting has improved through electronic exchanges through the Indiana*AIM* system,

accounts payable systems, Department of Revenue and across Medicaid Enterprise programs.

The Manage State Funds business process was assessed at MITA capability maturity level 1, due to a majority of characteristics affirmed at Level 1 and due to the lack of a documented process at this time.

Program Administration – Develop Agency Goals and Initiatives

FSSA and OMPP made efforts to assess their organizational structure, policy development, and recommend improvements by contracting with a consulting firm, KPMG, to document the roles and functions of their staff and divisions. An analysis of staff functions and division duties is well documented in the Organization Redesign Model. This document is very helpful in identifying strategic planning and recommended organizational changes. Continuing to implement the recommendations will provide OMPP with improved organizational structure and operational efficiencies. Additionally, agency goals are passed down to the Medicaid programs aligning program goals and objectives.

The 2005 FSSA Strategic Plan outlines goals and objectives for each of the FSSA Divisions, including multiple components for the Medicaid Enterprise. Tracking progress towards those strategic plan goals and objectives were not provided for review. The Validation Session group reported the Develop Agency Goals and Initiatives business process utilizes manual development and tracking using MS Word and Excel. Additionally, the group reports targets are reached 50% of the time, but noted that there has been continuous improvements to performance. Web enabled Prior Authorization

process is an example of a strategic goal that was implemented to achieve the efficiency and effectiveness of this process using automated and electronic means.

The Develop Agency Goals and Initiatives business process was assessed at MITA Capability Maturity Level 1, due to the affirmation of 100% of the Level 1 characteristics, without attaining all characteristics at Level 2.

Program Administration – Develop and Maintain Program Policy

The Develop and Maintain Program Policy process is administered at the FSSA level as well as by OMPP. OMPP policy staff review and assess the impact of state and federal regulations, QIO findings, and state and federal audit findings to develop and maintain program policy. At this time, their assessments and decision making functions are conducted through manual and paper-based processes. Indiana has increased electronic distribution of program policy through policy websites and e-mail correspondence. In assessing another characteristic of this process, we found non-standardized data exists across the enterprise; it varies by Medicaid program and program area making it difficult to compare across the enterprise.

Accordingly, the Develop and Maintain Program Policy business process was assessed at a MITA Capability Maturity Level 1. Also few Level 2 characteristics were affirmed, including: business rules being supported by some automated processing, automated processes bringing added value to the stakeholders, and utilization of electronic transactions.

Program Administration – Maintain State Plan

The Maintain State Plan business process is accomplished by a combination of manual and electronic operations. A review of the Standard Operating Procedures for State Plan Amendments documentation was conducted. Additionally, the Validation Session group described Indiana's Maintain State Plan business process. State Plan amendments are developed from changes to state or federal legislation or as a result of program changes or reporting requirements. The internal approval process is manual with multiple staff at various administrative levels needed for review. Program staff tracks implementation and progress of state plan amendments manually using MS Word or Excel documents. Indiana does submit state plan amendments electronically to CMS through email.

Indiana recently submitted an amendment to its State Plan to enhance the delivery of child health through the Indiana Health Information Exchange (IHIE), a collaboration of Indiana health care institutions.

The Maintain State Plan business process was assessed at MITA Capability Maturity Level 1, due to the affirmation of 100% of the characteristics at Level 1.

Program Information – Generate Financial & Program Analysis/Report

Manual and automated procedures comprise the Generate Financial and Program Analysis Reports business process. Program analysis reports are generated through Indiana*AIM* system and program databases for eligibility and provider information. Financial reports for accounting and state and federal budgeting categories are queried through the FSSA PeopleSoft

Financial Module. The need for some manual entry and use of Excel spreadsheet tracking and reporting is utilized. Staff analysis of reports is needed to ensure program benefits meet the needs of the members. Different reports require various reporting timeframes from quarterly to annually. Indiana does not have standardized enterprise analysis and reporting tools, but rather program specific. Non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly.

One hundred percent of the characteristics at MITA Capability Maturity Level 1 were affirmed for the Generate Financial & Program Analysis/Report business process.

Program Information – Maintain Benefit/Reference Information

OMPP contracts with EDS to maintain Indiana's MMIS, the Indiana*AIM* application. Most of the Maintain Benefit/Reference Information business process is automated with some manual processes. The Indiana*AIM* system processes benefit and reference information relating to, but not limited to claim approvals or denials, provider types and TPL data. Loading reference materials for claims processing is primarily manual. Once the information is loaded, the claims processing is fully automated based on that reference file. Any additions or adjustment to Edit Claim/Encounter, Audit Claim/Encounter can be changed in Indiana*AIM*. Indiana*AIM* also maintains benefit and reference information related to providers that can be generated using the DSS Profiler. When outpatient, inpatient, nursing home facility type data is changed or updated, it can easily be uploaded and entered. Reports can then be accessed electronically both on an ad hoc and a regularly scheduled

basis. Enhancements are continually added to Indiana*AIM* to increase timeliness and accuracy of data and to add value to stakeholders.

Triggers such as new programs or codes require manual processes to review and upload the information to the reference file. Once the information is loaded, remaining processing is automated.

The Maintain Benefit/Reference Information business process was assessed to achieve a MITA Maturity Level 1.

Program Information – Manage Program Information

While Indiana*AIM* does maintain much of OMPP's program information electronically, each Medicaid program, administered by other divisions on behalf of OMPP, also maintains additional program specific information in various sources. Program information such as established rates, drug formularies, and benefit package information can be accessed via OMPP, MCO, CMO and IHCP vendor web portals. Indiana*AIM* acts as a centralized repository to track activity and apply changes to program information for cross-program exchanges.

Manage Program Information business processes reached a MITA Maturity Level 1.

Program Quality Management – Develop and Manage Performance Measures and Reporting

The Develop and Manage Performance Measures and Reporting business process is a primarily manual process with some electronic exchange of information. Developing, managing and monitoring performance measures are program specific and vary by each Medicaid program. Each of the Medicaid programs has targeted program quality goals and benchmarks. Many targets are calculated using metrics, Excel files, and databases. Data format and reporting areas such as program services and utilization vary by program. Some standardized clinical, claims and performance data is reported through Indiana*AIM*. Performance measures are re-assessed regularly to respond to state and federal regulations.

The Hoosier Healthwise program has developed a Quality Strategy initiative. The Quality Strategy provides a framework to communicate the State's vision, objectives and monitoring strategies addressing issues of health care cost, quality and timely access in Medicaid managed care. It encompasses an interdisciplinary collaborative approach through partnerships with enrollees, stakeholders, governmental departments and divisions, providers, contractors, managed care organizations (MCOs), managed behavioral health organizations (MBHOs), academics and community groups.

A committee comprised of the OMPP Director of Quality and Outcomes and members of the Quality Improvement committee, including the MCO Quality Strategy staff have been tasked to develop and monitor the Quality Strategy. The Committee reviews and uses available MCO monitoring data to analyze and identify trends, discuss findings and identify and prioritize opportunities for strategically integrating QI activities into overall monitoring of the MCOs. The Committee also has workgroups to develop measures as well.

The Committee and associated workgroups have developed measures using the National Committee for Quality Assurance NCQA's Healthcare Effectiveness Data and Information Set (HEDIS). By using NCAQA benchmarks and HEDIS data sets, common metrics can be measured across each of the Managed Care Organizations. As of 2006, 26 HEDIS measures are collected.

The Develop and Manage Performance Measures and Reporting business process achieved a MITA Maturity Level 1, because not all of processes reached at MITA Maturity Level 2.

Program Quality Management – Monitor Performance and Business Activity

The Monitor Performance and Business Activity business process uses a combination of manual processes such as meetings, discussions and some electronic interchange of data sets. The Hoosier Healthwise Quality Strategy initiative has developed a comprehensive framework for measuring performance outcomes across each MCO. A Quality Strategy Committee and workgroups monitor and analyze established NCQA benchmarks and outcome measures using a variety of different data sets including the HEDIS. The Quality Strategy Committee who provides oversight of the initiative meets quarterly and conducts a public meeting following each of its quarterly meetings to report on quality initiatives and to solicit input. The OMPP Director of Quality and Outcomes, who reports directly to the Indiana Medicaid Director, chairs this committee, and ultimately assumes leadership of Indiana's Quality Strategy for the Indiana Health Coverage Program (IHCP), of which Hoosier Healthwise is a part. Some of the smaller work groups, the Behavioral Health Workgroup and the Neonatal Outcomes Workgroup have

been created to monitor quality issues related to behavioral and neonatal performance measures and outcomes

Monitoring activities are conducted through an independent External Quality Review Organization (EQRO) that, who produce a quarterly "Dashboard Report", monthly site visits and regular data analysis. The EQRO reviews Federal and State regulatory requirements and performance standards as they apply to MCOs annually. A quarterly "Dashboard Report" is published that summarizes performance across MCOs for 22 financial and non-financial reporting requirements that are the most significant indicators of MCO performance. Additionally, OMPP Policy Analyst staff performs monthly site visits to MCOs.

The Monitor Performance and Business Activity business process was assessed to achieve a MITA Maturity Level 1.

3.5.4 Strengths and Weaknesses for Current Business Processes

Key strengths and weaknesses of the current business process are summarized here by Program Management business process:

Strengths in Current Business Processes

Strengths within the existing processes include:

- OMPP continues to broaden the state's level of services and value driven services by developing new programs such as HIP and Care Select.

- Development of FSSA Financial Management Accounts Procedure Manual will standardize many financial business processes across the Medicaid Enterprise.
- Implementation of FSSA Financial Management PeopleSoft Financial Module has improved data accuracy and improved timeliness for many financial management operations.
- Developing a Federal Funding Unit within FSSA Financial Management will improve management and reporting of federal funds, F-MAP, and FFP processes.
- OMPP continues to increase utilization of electronic communication and distribution of outreach and education materials to members, providers, and stakeholders.
- Developing the Drug Formulary process is almost fully automated.
- Indiana's Hoosier Healthwise program Quality Strategy clearly defines goals for HEDIS, OMPP targets and NCQA benchmarks and detailed means of supporting and reassessing them.
- Increasing the use of electronic and automated operations to support the budgeting processes reduces staff time.

Weaknesses in Current Business Processes

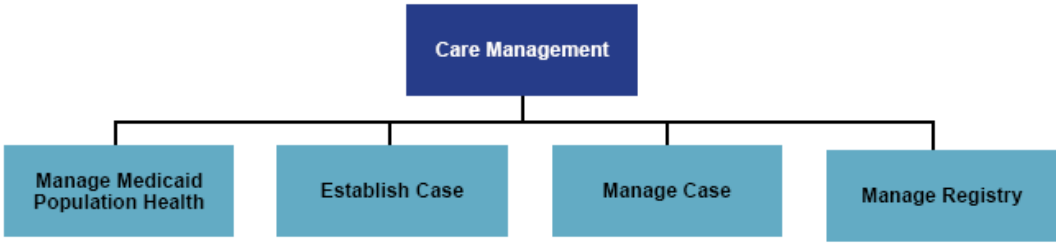
Weaknesses include:

- OMPP can continue to Improve Timeliness, Data Access and Accuracy, Cost Effectiveness, Accuracy of Process Results or Utility or Value to

Stakeholders by increasing the use of automated reporting and increased use of electronic data exchange.

3.6 Care Management

3.6.1 Business Area and Business Process Description



The Care Management business area illustrates the growing importance of care management as the Medicaid program evolves. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify clients with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics and needs and promotes health education and awareness.

Care Management includes Disease Management; Catastrophic Case Management; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Population Management; Patient Self-Directed Care Management; Immunization and other registries; Waiver Program Case Management; and programs yet to come. With individual patient and case manager access to clinical data and treatment history, Care Management evolves and increases in importance in the Medicaid enterprise.

3.6.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Establish Case	The Establish Case business process uses criteria and rules to identify target member populations for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication.Cases may be established for:- Medicaid Waiver program case management-- Home and Community-Based Services-- Other- Disease management- Catastrophic cases- EPSDT- Population managementEach case type is driven by different criteria and rules, different relationships, and different data.	1
Manage Case	The Manage Case Business processes collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. Case managers administer, monitor and manage member services.	1
Manage Medicaid Population Health	These business process designs and implements strategies to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The input to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media. .	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Manage Registry	This business process operates a registry (e.g. immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.	1

3.6.3 Capability Maturity Findings

The Care Management (CMO) business area operations in Indiana are performed through a combination of manual and automated processes. Paper based and manual decision making processes occur as well as automated operations through CMO databases and EDI processing through the MMIS (IndianaAIM). Care Management business processes focus on establishing and managing a case, managing Medicaid population health and managing registries. The data exchange requirement for Care Management processes occur by paper, mail, phone, electronic mail, and EDI HIPAA compliant claims transactions. Web enabled EDI exchange for these processes appear limited to accessing member information and claims data.

The Medicaid Enterprise has been engaged in a number of changes to its Care Management business area, process and programs. Recently, OMPP has changed its Care Management Program from Medicaid Select to Care Select in the last year. As a part of this transition, OMPP has contracted with two new vendors Advantage and MDwise as Care Management

Organizations. As of March 1, 2008 phased implementation of the program has been rolled out throughout Indiana.

The Hoosier Healthwise program is Indiana's health care program for children, pregnant women, and low-income working families. The managed care organizations (MCO's) supporting the Hoosier Healthwise program are MDwise, Anthem, and MHS. Additionally, the Healthwatch program for Early Intervention Services – Early Periodic Screening Diagnosis & Treatment and child immunization services are also considered a part of coordinated services for care managed populations.

The table below identifies Entities and the high level business process for which they are responsible within the Indiana Medicaid Enterprise.

ENTITY	CARE MANAGEMENT BUSINESS PROCESS
Enrollment Broker – MAXIMUS **CMOs – MDwise & Advantage** **MCO – MDwise, MHS & Anthem**	CM – Establish Case
CMOs – MDwise & Advantage **MCO – MDwise, MHS & Anthem**	CM – Manage Case
CMOs – MDwise & Advantage **MCO – MDwise, MHS & Anthem** **Fiscal Agent – EDS**	CM – Manage Medicaid Health Population
OMPP and Indiana State Department of Health	CM – Manage Registries

OMPP has published Managed Care (MCO) and Care Management organization (CMO) policies, procedures, and reporting requirements that

are accessible electronically through the web. The MCOs/CMOs have program information, published policies and procedures that are accessible through their websites as well. Additionally, documented policies and procedures were reviewed for services reaching special types of services such as Early Intervention Services – Early Periodic Screening Diagnosis and Treatment (EPSDT) and for special needs populations such as Waiver, and Home and Community Based populations.

Documentation reviewed outlines Indiana's services of care coordination, case management, disease management and utilization management that include, but are not limited to: targeted case management for pregnant women, mentally ill or emotionally disturbed and home health services and long term acute care hospitalization. The Indiana Care Select Program provides a holistic view of individual needs, including medical, social, functional and behavioral for eligible Medicaid members.

The Manage Medicaid Health Population process uses a combination of manual and automated business processes. Data mining from IndianaAIM and other databases are used to gather data to try to identify and target special needs populations. However, manual mechanisms supporting the process still exist such as mailing paper packets to eligible members to assess health status. The Manage Registry business processes are mostly automated, but some manual interventions exist.

All Care Management business processes were assessed to possess most capabilities at Maturity Level 1, with some processes possessing capabilities at MITA Maturity Level 2. No Current Capabilities were assessed to possess characteristics at MITA Maturity Level 3 or higher.

Provider Association Focus Group Comments

The Provider Association Focus group indicated that today, there is little case management performed on the general Indiana Medicaid population outside of the Care Select program. Providers suggested that better health outcomes could be realized if all members were medically screened or case managed on a regular basis. The lack of case management for the general Indiana Medicaid population can be problematic as members are not necessarily taking appropriate preventive measures which can lead to late detection of serious illnesses or conditions and an overutilization of emergency rooms. Other observations related to current processes included that there was little if any Member education or outreach performed today and that there is a need to streamline all of the various registries (Immunization, HIV, Lead Screening, etc...) in use by FSSA today to allow for comprehensive data analysis and reporting.

It was suggested during the Provider Association stakeholder meeting that Care Management responsibilities should be clarified and streamlined between Care Managers, Case Managers and guardians for such person with developmental disabilities. Providers stressed the need for greater clarity and coordination between such case management functions to ensure that all needed services are provided without duplication.

State Feedback to Provider Association Focus Group Comments

All Hoosier Healthwise members receive health screenings at enrollment. Additionally, each Hoosier Healthwise MCO is required to have an asthma and disease management program at minimum. However each MCO offers additional disease management programs, for example diabetes, high-risk pregnancy, etc. Providers may not be aware of these programs. A fee-for-

service member, such as those in Medicare, Nursing Homes, Emergency-only services, care is being managed by the appropriate entities.

Business Process Findings

The following are assessment findings for business processes in Care Management

Establish Case

OMPP uses a combination of manual and electronic processes for establishing a case. Prospective eligible member information is accessed via EDI through IndianaAIM to determine Care Select or Hoosier Healthwise eligibility. Indiana's Enrollment Broker, MAXIMUS may assist members to choose a PMP who is enrolled in the Care Select or Hoosier Healthwise program. Outreach efforts to new members are conducted through phone calls, mailings and distribution of electronic program information by CMOs/MCOs. Outreach materials available in English and Spanish explain member enrollment and provider services.

A Health needs screening is conducted by MAXIMUS for each Hoosier Healthwise member. MCO's will do a further assessment if the health needs screening determines that follow-up is necessary. MAXIMUS send the file automatically to the MCO's with the results of the health needs screening.

Once enrolled in the Care Select program, an initial health risk assessment is completed for each member. A team approach is used to create individual member plans targeting specific needs of members. Teams consist of Care Managers, Case Manager, PMPs, and other utilization staff. Standardized

tools specific to the populations are used to assess the level of care needed. Members are stratified into subpopulations for their coordination of care. These processes include both manual and electronic business process, including staff decision making and data exchange with claims data.

The Establish Case business processes achieve a MITA Maturity Level 1 because not all business processes were reached at MITA Maturity Level 2. The Establish Case business processes that reached a MITA capability maturity level 2 related to using a combination of manual and electronic processes to validate member identification.

Manage Case

The coordination of care and managing a case uses both manual and electronic business processes. Member information is stored electronically in databases and IndianaAIM. Each MCO/CMO vendor has separate databases that maintain member care plan information. Paper processes, team review meetings, utilization data and claims data are used to monitor and re-assess care plans. Care plan updates and changes are currently not automatic or available to other Medicaid wide programs. For Care Select, individual care plans are available via the web for providers, but at this time, the web cannot be used for updating purposes.

The Manage Case business process achieved a MITA Maturity Level 1 overall, because not all characteristics of MITA Maturity Level 2 are accomplished. The Manage Case characteristic that reached a MITA capability maturity level 2 is related to requesting member and provider information through EDI or the Internet.

Manage Medicaid Population Health

Managing the Medicaid Population Health uses a combination of manual and electronic processes. Indiana targets individuals with similar characteristics and needs through EDI exchanges through IndianaAIM, registries, and other databases. Demographic, Vital Statistics, claims data and health needs information are assessed regarding the Medicaid population. A Quality Strategy Group establishes metrics and measures for each care program. HEDIS data is used to assess quality across the care programs. Paper and web based information are created and distributed for outreach efforts for targeted Medicaid populations. OMPP distributes regular bulletins and program information. Vendors conduct outreach and education efforts to providers through regular community meetings and distributed materials.

Program performance measures are monitored and reported on a regularly scheduled basis by the CMOs/MCOs. Targeted performance indicators have specific metrics, tools and reporting timelines outlined by OMPP. Reporting processes are documented in the MCO/CMO Reporting Manuals. Reporting requirements for special needs populations, disease management, EPSDT, waiver and quality measures are found in program specific manuals. They include, but are not limited to reporting: quality of care management, medical necessity, and utilization of emergency services. The OMPP Care Program Quarterly Dashboard Reports were provided for review.

The Manage Medicaid Population Health business process achieved a MITA Maturity Level 1 because not all of the characteristics of MITA Maturity Level 2 were achieved. The Validation Session confirmed that those Manage Medicaid Population characteristics reaching a MITA capability maturity level

2 are: improvements to members having web based access to program outreach and education materials as well as automating access to data and sharing standardized administrative data such as member demographics.

Indiana reached a MITA capability maturity level 3 for the characteristic of outreach and education being immediately available to members across collaborating agencies through web based tools.

Manage Registry

The Manage Registry process in Indiana is primarily performed by the Indiana State Department of Health (ISDH). ISDH manages the following registries which have Medicaid Information:

- Lead Screening
- Chronic Disease Management System
- ISDH – Children and Hoosier Immunization Registry Program (CHIRP)
- ISDH – Infant Birth Defect and Problems Registry

Other registries managed by ISDH which may have Indiana Medicaid information contained within them, but which are not exclusively for Medicaid members include:

- Cancer Registry
- HIV Registry

While many of the Manage Registry business processes at ISDH are automated through electronic data exchange, there is a manual option

available (as mandated by law) for all providers and case managers to utilize to submit registry information. Almost all updates to the registry (reported as 98%) are updated electronically. Information about Medicaid populations for Disease Management, Case Management, EPSDT, Population Management, Patient Self-Directed Care Management, and Immunization can be found through registries and databases.

Email communication from ISDH was provided to explain the business processes related to the Lead screening Registry, Children & Immunization Registry Program (CHIRP) and Infant Birth Defect & Problems Registry that have Medicaid information and are managed by ISDH. A Traumatic Brain Injury registry is currently being developed by ISDH. Clinical data is sent from the OMPP DSS electronically to ISDH for the registries. Both OMPP and ISDH manage the Chronic Disease Management System (CDMS). CDMS registry policy and procedure information is available through a manual and website link. This information was reviewed for this assessment. MCO/CMOs educate providers on using the CHIRP registry for registering immunization via the web link. OMPP manages the registries for Population Management and Self-Directed Care. OMPP accesses registry data for their Medicaid population through data exchanges with ISDH.

The Manage Registry process for the Indiana Medicaid Enterprise was assessed at MITA Maturity level 1 overall. ISDH documentation validated businesses processes for the Manage Registry process to achieve a MITA Maturity Level 1 with many, but not all characteristics reaching a MITA Maturity Level 2. Those characteristics reaching a MITA Maturity Level 2 include improvements to timeliness of data updates from use of automation, improvements in timeliness of data extracts from records in registries due to

use of automation, and automated processing of registry updates from providers submitting electronically.

3.6.4 Strengths and Weaknesses for Current Business Processes

Strengths of Current Business Processes

Key strengths of the current Care Management business processes include:

- Most program policies and procedures are well documented.
- Member information can be accessed electronically or automatically through systems.
- Program outreach and education material and information are available electronically or through the internet.
- Performance measures area standardized and reported timely.
- Manage Registry business processes are mostly automated data extract business processes using clinical data.

Weaknesses of Current Business Processes

Weaknesses include:

- Member information is not automatically updated through Health Information Exchange system.

- A member's care plan information is not accessible to the Medicaid Enterprise, but primarily restricted to each MCO/CMO entity .
- OMPP can Improve Timeliness, Data Access and Accuracy, Cost Effectiveness, Accuracy of Process Results or Utility or Value to Stakeholders by increasing the use of automated reporting and operations and electronic data exchange
- Enhancing measuring and reporting effectiveness of outreach efforts, member satisfaction for cost analysis will assist the new Care Select program for strategic planning purposes.

3.7 Program Integrity Management

3.7.1 Business Area and Business Process Description

The Program Integrity business area incorporates those business activities that focus on program compliance (e.g., auditing and tracking medical necessity and appropriateness of care and quality of care, fraud and abuse, erroneous payments, and administrative abuses).

Program Integrity collects information about an individual provider or member (e.g., demographics; information about the case itself such as case manager ID, dates, actions, and status; and information about parties associated with the case).

The business processes in this business area have a common purpose (e.g., to identify case, gather information, verify information, develop case, report on findings, make referrals, and resolve case). As with the previous business areas, a single business process may cover several types of cases. The input, output, shared data, and the business rules may differ by type of case, but the business process activities remain the same.

This business area will mature with access to clinical data that improve the capability for identifying real cases of program abuse. Today this business area concentrates on SUR activities, fraud detection, and other types of program safeguards. Although Program Integrity activities continue to have a place as core business processes mature, their focus is predicted to shift from retrospective analysis to prospective and concurrent application of business rules.

3.7.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	**Process Description**	**Aggregated Capability Maturity Level**
Identify Candidate Case	The Identify Candidate Case business process uses State specific criteria and rules to identify target populations (e.g., providers, contractors, or beneficiaries), establishes patterns or parameters of acceptable/unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Candidate cases may be identified for:- Provider utilization review- Contractor- Beneficiary utilization review- Potential fraud- Drug utilization review- Quality review. Each	1

Business Process – *Business Capability*	**Process Description**	**Aggregated Capability Maturity Level**
	type of case is driven by different State criteria and rules, different relationships, and different data.	
Manage Case	The Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, or beneficiary from the Medicaid program; or the case may be terminated or suspended.Individual State policy determines what evidence is needed to support different types of cases:- Provider utilization review- Provider compliance review- Contractor utilization review- Contractor compliance review- Beneficiary utilization review- Investigation of potential fraud- Drug utilization review- Quality review- Performance review. Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.	1

3.7.3 Capability Maturity Findings

The Program Integrity area appears to be performed through a series of primarily manual operations with a minimal automation of key processes. From our assessment it appears that the Medicaid Enterprise is making a concerted effort to ensure program integrity, and has processes to identify and correct improper behavior within the Medicaid program. As part of this effort, the enterprise has implemented the DSS Profiler, which is an integrated query, reporting and analysis tool. The implementation of the DSS Profiler has greatly assisted staff, because of its automation and streamlining capabilities.

The SUR department coordinates activities with the other business areas at Health Care Excel, with EDS and other IHCP contractors, and with the State. This coordination and communication has improved the program integrity process. As previously mentioned, another advantage is that the vendor completes research within OMPP databases, which eliminates the need to re-enter data and reduces errors.

Although positive aspects exist, the primary disadvantage to the current program integrity process is the heavy reliance on manual processes. There is room for growth in automating both the identification and management of cases. At the current time, it appears as if there are two primary methods that staff members use to identify cases: the receipt of phone calls and the running the DSS Profiler. The management of cases has similar process in place. Both data requests and updates appear to remain a manual process.

Provider Association Focus Group Comments

There were no comments or concerns related to the current capabilities in this business area raised at the Provider Association Focus Group meeting.

Business Process Findings

The following are findings for each business process within the Program Integrity Area:

Identify Candidate Case

The identification of cases appears to be a primarily manual process, based on staff review, research and response to a case-by-case request. One automated aspect of the process is the use of DSS Profiler reports. These reports are used to identify those providers and members who are potentially misusing procedure codes or services.

Manage Case

During the management of cases, contact is not automated and research is completed by staff within OMPP databases. Accordingly a manual request must be made for information about each case. Similarly, case updates also appear to be a manual process. It is helpful that the vendor completes research within OMPP databases, thus eliminating the need to re-enter data and reducing errors.

Overall, there are several components of the program integrity process that are shared among the SUR business areas. Although automation of process may be lacking, the manual process contributes to streamlining the process for staff. Effective communication and information

exchange is critical for building and managing strong business relationships, public-private partnerships and vendor performance management. The current Indiana Medicaid Enterprise process relies heavily on external business relationships, thus making it critical that the State maintains high levels of communication as it attempts to achieve its Envisioned Future.

3.7.4 Strengths and Weaknesses for Current Business Processes

Strengths of Current Business Processes

Key strengths within the existing program integrity processes include:

- The utilization of DSS Profiler reports to identify those providers and members who are potentially misusing procedure codes or services.
- When managing cases, there is a three-tier Quality Control process, resulting in more consistency across cases.
- Vendors work within OMPP databases, so additional data loading for identifying and managing cases is not necessary. The pharmacy auditing process exchanges data files with the MMIS so very little manual intervention is required.
- Concurrent auditing for pharmacy claims allows for automated fax letters to generated and distributed to providers after systematic algorithms are executed.

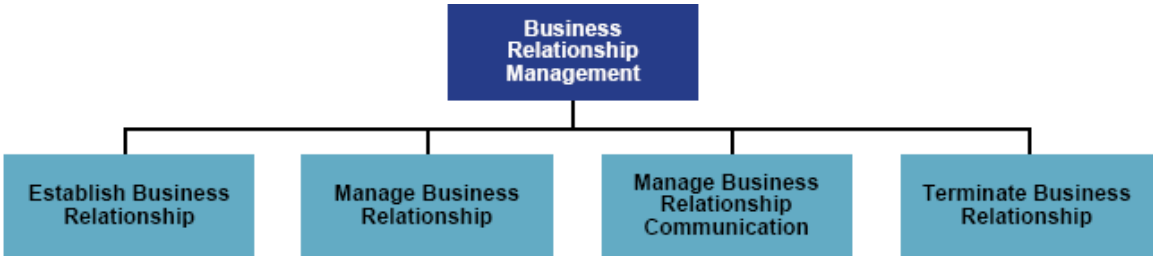
Weaknesses of Current Business Process

Weaknesses of current processes include:

- Even with the use of the DSS Profiler, much of the Program Integrity work remains a manual process, especially at the Manage Case level.

3.8 Business Relationship Management

3.8.1 Business Area and Business Process Description



The Business Relationship Management (BRM) area focuses on the ever-increasing importance of effective communication, collaboration and coordination of the essential Medicaid enterprise business relationships between in-State agencies and inter-State and Federal agencies. This business area includes the standards to enable interoperability across the many areas of the Medicaid Enterprise and also owns the standards for interoperability between the various Enterprise areas and their business partners. BRM contains business processes that have a common purpose to: establish the interagency service agreement; identify the types of information to be exchanged; identify security and privacy requirements; define communication protocols; and, oversee the transfer of information.

In most State Medicaid Agencies, data exchange and intra-agency service agreements are commonplace. Secure technological interfaces allow Medicaid Enterprises to send and receive information from in-State sister divisions or agencies, as well as from other inter-State or Federal data-sharing partners. Data exchanged between State Medicaid agencies and other agencies and States is primarily processed manually, meaning that requests are received and responded to in an ad hoc manner.

The growing emphasis on Health Information Technology and Exchange is creating an environment where health information exchange is recognized as crucial to improving health outcomes, care delivery and overall population health. The national Standards Harmonization and Product Certification efforts are creating the means for interoperability within States and across the nation, through private and secure infrastructures that can be tailored to State and local business agreements. The BRM processes focus on defining a progressive path for improvement of capability maturity to support the cornerstones of the Value Driven Health Care Framework consisting of (1) Interoperable Electronic Health Records, (2) Quality Benchmarks and Transparency, (3) Price (Episode of Care) Benchmarks and Transparency and (4) Incentives for Provider Performance.

3.8.2 Current Capability Maturity Assessment Results

Business Process – *Business Capability*	**Process Description**	**Aggregated Capability Maturity Level**
Establish Business Relationship	The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid agency to enter into business partner relationships with other stakeholders. These include Memoranda of Understanding (MOU) with other agencies, electronic data interchange agreements with providers, managed care organizations and other partners, CMS and other Federal agencies, as well as Health Information Exchanges and Regional Health Information Organizations.	1

Business Process – *Business Capability*	Process Description	Aggregated Capability Maturity Level
Manage Business Relationship	The Manage Business Relationship business process maintains the agreement between the State Medicaid agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.	1
Manage Business Relationship Communication	The Manage Business Relationship Communication business process produces routine and ad hoc communications between the business partners.	1
Terminate Business Relationship	The Terminate Business Relationship business process cancels the agreement between the State Medicaid agency and the business partner.	1

3.8.3 Capability Maturity Findings

All of the Indiana Business Relationship Management business processes in existence today fall within the characteristics defined by MITA as Maturity Level 1, which means that the business processes are primarily dependent on manual (paper, telephone and fax) processes, data formats are inconsistent, information is manually validated, communications are inconsistent and not coordinated between programs/agencies, and staff decision-making is performed without timelines or alerts to ensure that the processes continue to move forward in an effective and efficient manner.

In the past, both the State of Indiana and FSSA have focused on strategic priorities for reforming and streamlining their contracting and procurement

processes and those efforts have brought some success. For example, OMPP has key personnel who are dedicated to improving the contracting and procurement processes and they have created databases to track contracts and perform some ad hoc reporting. Despite this progress, the overall BRM process remains constrained by lengthy, largely paper-driven, dated, manual practices.

Provider Association Focus Group Comments

No comments or concerns related to the processes within this business area were received during the Provider Association Focus Group meeting.

Business Process Findings

The following are findings for each business process within the Business Relationship Management Area:

Establish Business Relationship

All information (contact numbers, forms, etc.) is available on the State's website for vendors to establish a relationship with the State. Interested external parties are responsible for initiating communication with the State, researching how to become a vendor or partner, how to learn about bidding opportunities, the status of contracts, and other critical issues related to establishing a business relationship with the State. In terms of the State reaching out to vendors, there are no documented, consistent State communication processes to reach out to potential external vendors or other partners.

During the Validation Sessions, the group expressed particular concern about the uncoordinated and unmanaged use of Memorandum of Understanding (MOUs). Currently, MOUs are initiated, validated, approved, updated and terminated manually and inconsistently. There are no standardized formats or processes for initiating, validating, approving, managing, updating or terminating MOUs, and as a result, they are not handled timely. MOUs are manually entered into the CMS system for tracking the MOU activation date, but they are not entered into KMS. Executed MOUs are also uploaded onto the SharePoint online repository and are therefore available to people who have access to the established SharePoint site. Any reports generated with regard to MOUs are not used to manage them. MOUs are only valid for two years and must be re-initiated after the term expires. There is no documented, standardized way to terminate MOUs; termination generally consists of allowing the MOU to lapse after the two year term.

Manage Business Relationship

The validation session group confirmed that the BRM functions are primarily performed through a series of labor intensive, manual and paper based operations, with little to no transparency in the overall process flow across the divisions and vendors that comprise the Medicaid Enterprise.

There are no documented procedures for the management of business relationships that are based on an MOU. Currently, application and agreement data is not standardized, processes are manual and the management of applications and agreements is all done manually.

Manage Business Relationship Communication

Indiana's contracting processes exhibit a preference for local vendors. Marketing/communication processes used to expand the vendor pool to provide the State with multiple vendor options are not documented and consistent. Without a more open and transparent business communication process it is likely to be difficult for the Indiana Medicaid Enterprise to fully realize its Envisioned Future.

There are no standardized business rules between programs or agencies, therefore business decisions and communications are inconsistent, labor intensive and untimely.

Any communication concerning MOUs is done manually and inconsistently and is therefore generally untimely.

Terminate Business Relationship

There is no documented process for terminating business relationships in Indiana and as a result, agreements are terminated manually and inconsistently.

The validation session group acknowledged that the Enterprise recognizes the need to establish standard boilerplate termination language for all agreements and MOUs, including an early termination option clause, and create a dispute and grievance process for escalating issues.

3.8.4 Strengths and Weaknesses for Current Business Processes

Strengths of Current Business Process

- IDOA, OAG and SBA have established some standardized forms, formats and approval processes for some data used to establish business relationships.
- Efforts are being made to standardize, manage, manually track and monitor MOUs.

During the Validation Sessions, the group stated that the Enterprise intends to define and establish a standardized, consistent MOU process that can be used across the State and will enable the use and sharing of MOU information.

The group also confirmed that the Enterprise intends to expand its use of PeopleSoft to automate and improve the effectiveness and efficiency of all Business Relationship Management functions.

Weaknesses of Current Business Process

Weaknesses identified include:

- Processes are lengthy, largely paper-driven, labor-intensive, inconsistent, manual practices.
- No documented, standardized procedures for MOUs across the Indiana Medicaid Enterprise.

- Limited management of MOUs.
- No established process (other than letting an MOU expire after two years) to terminate a business relationship.

4 Technical Capability Findings

Of the three architectures in the MITA Framework 2.0 – Business, Information and Technical – the Technical Architecture is the least well developed architecture. Recognizing this fact, CMS has not required the assessment of technical capabilities to be a part of the required MITA Assessment, and has requested the Private Sector Technology Group Technical Architecture Committee, of which 4TG is a key partner, to assume responsibility to enhance and expand the Technical Architecture and artifacts based on most recent emerging architectural standards. Accordingly, the Technical Architecture is taking a very different strategic direction, than what is currently documented in the MITA 2.0 framework and the Technical Capabilities Matrix (TCM). .

However, the Indiana Request for Services indicated that the MITA Assessment should utilize the MITA 2.0 Technical Capability Matrix (TCM) to identify technical capabilities to "enable business processes and provide general improvement." Thus this section addresses that requirement by providing a high level summary of Medicaid Enterprise's Technical Capabilities. This summary is both a reflection of the rudimentary state of the TCM, and the current limitations of the Medicaid Enterprise Technical Capabilities. The following table represents the current, MITA 2.0 Technical Capability Matrix (TCM) at maturity Level 1.

TECHNICAL CAPABILITY MATRIX[4]	
Technical Area	*Level 1. Capability Definitions*
1. BUSINESS ENABLING SERVICES (BES)	
1.1. Forms Management	Manual data entry on hardcopy forms
1.2. Workflow Management	Manual routing of hardcopy files to individuals involved in processing
1.3. Business Process Management	Manual, by user
1.4. Business Relationship Management	Manual (e.g., by attaching annotations to case files)
1.5. Foreign Language Management	
1.6. Decision Support	
1.6.1. Data Warehouse	
1.6.2. Data Marts	
1.6.3 Ad hoc Reporting	Ad hoc reporting, typically using coded procedures
1.6.4 Data Mining	Data mining to detect patterns in large volumes of data, typically using coded procedures
1.6.5 Statistical Analysis	Statistical analyses (e.g., regression analysis), typically using coded procedures
1.6.6 Neural Network Tools	None Analyses using neural network (e.g., learning) tools
2. ACCESS CHANNELS (AC)	

[4] Blanks in the TCM Level 1 Capability definition column are as a result of incomplete TCM in MITA Framework 2.0.

TECHNICAL CAPABILITY MATRIX[4]	
Technical Area	*Level 1. Capability Definitions*
2.1. Portal Access	Beneficiary and provider access to appropriate Medicaid business functions via manual or alphanumeric devices
2.2. Support of Access Devices	Beneficiary and provider access to services via manual submission, alphanumeric ("green screen") devices or EDI
3. INTEROPERABILITY CHANNELS (IC)	
3.1 Service Oriented Architecture	Non-standardized definition and invocation of services Service support using architecture that does not comply with published MITA service interfaces and interface standards
3.1.1 Enterprise Services Bus	None or Non-standardized application integration
3.1.2. Orchestration and Composition	Non-standardized approaches to orchestration and composition of functions across the Medicaid MMIS
3.2. Standards-Based Data Exchange	Ad hoc formats for data exchange
3.3. Integration of Legacy System	Ad hoc, point-to-point approaches to system integration
4. DATA MANAGEMENT & SHARING (DMS)	
4.1. Data Exchange Across Multiple Organizations	Manual data exchange between multiple organizations, sending data requests via telephone or e-mail to data processing organizations and receiving requested data in nonstandard formats and in various media (e.g., paper)
4.2. Adoption of Data Standards	No use of enterprise- wide data standards
4.3. OM1 Authorize Treatment Plan	
5. PERFORMANCE MEASUREMENT (PM)	

TECHNICAL CAPABILITY MATRIX[4]	
Technical Area	*Level 1. Capability Definitions*
5.1. Performance Data Collection & Reporting	
5.2. Dashboard Generation	
6. SECURITY & PRIVACY (SP)	
6.1. Authentication	Access to MMIS system capabilities via logon ID and password
6.2. Authentication Devices	
6.3. Authentication & Access Control	
6.4. Intrusion Detection	
6.5. Logging & Auditing	Manual logging and analysis
6.6. Privacy	Procedural controls to ensure privacy of information
7. FLEXIBILITY, ADAPTABILITY & EXTENSIBILITY (FAE)	
7.1. Rules Driven Processing	Manual application of rules (and consequent inconsistent decision making)
7.2. Extensibility	Extensions to system functionality that require pervasive coding changes
7.3. Automate Configuration & Reconfiguration Services	Configuration and reconfiguration of distributed application that typically requires extensive hard-coded changes across many software components and/or applications across the enterprise (and with significant disruption)
7.4. Information of New Technology	Technology Dependent Interfaces to applications that can be significantly affected by the introduction of new technology

To conduct this portion of the MITA Assessment, 4TG relied heavily on the findings of numerous recent assessments that provided more than sufficient documentation that no current Technical Capabilities for the Medicaid Enterprise exceed a Level 1. These findings were documented and reiterated across multiple studies, reports and recommendations, found in Appendix 7.3 of this deliverable.

While a complete technical capability assessment is not possible at this time due to the lack of definition and specificity in the MITA 2.0 Framework, 4TG was able to determine the following general findings:

- There is a profound level of fragmentation across FSSA Divisions, services and systems. This affects Medicaid Enterprise business processes and leads to inefficiencies in some of the processes. Therefore, it is not surprising to find a low Technical Capability Maturity level and lack of Technical Services that span the Medicaid Enterprise.

- The primary system supporting the Medicaid Enterprise, Indiana's Advanced Information Management System (AIM) or the Medicaid Management Information System, is outdated, and difficult to maintain or modify.

- The Individual Client Eligibility System (ICES), used to determine eligibility for IHCP is also a legacy system that is outdated, lacks necessary client information, and is difficult to maintain or modify.

- There is no consolidated view of all Indiana Medicaid Data. This makes reporting on almost any facet of the Indiana program

impossible. There is a need for an Enterprise wide data warehouse to allow for reporting on population health, program financial reporting and health outcomes.

- There is a need for self-service options such as a web portal that allows members and providers to perform a majority of their business processes over the Internet. For processes that must maintain some level of paper based processing, there is a need for imaging and process workflow technology to improve the efficiency of Medicaid Enterprise business processes.

Before the Medicaid Enterprise can realize benefits from Technical Capabilities, Services and Systems, substantial work will need to be performed to determine the level of standardization and integration necessary to realize the Envision Future.

To determine the Target Technical Capabilities it will be necessary for the Medicaid Enterprise to set priorities to achieve its vision, identify the key business processes that enable these priorities, and the standardization and integration of Technical Capabilities and Services to achieve this end.

Like the Indiana Office of Technology (IOT), whose mission is to provide cost-effective, secure, consistent, reliable enterprise technology services to its partner agencies so they can better serve Hoosier taxpayers, the Medicaid Enterprise needs to define its business enterprise strategies and priorities to enable business driven technology services.

5 Conclusion and Next Steps

The Indiana Medicaid Enterprise MITA Current Capabilities Assessment represents the findings of a "point-in-time" assessment of the current or "As Is" capability maturity level of the core business and technical capabilities of the Indiana Medicaid Enterprise.

The overall average capability maturity level of the Indiana Medicaid Enterprise for all MITA business process is at a ***Level 1*** or lowest level of capability maturity, meaning the Indiana Medicaid Enterprise "focuses on meeting compliance thresholds for State and Federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment claims for appropriate services." The Current Capability Assessment provides the baseline against which the Target or "To Be" Assessment as well as future progress towards the Medicaid Enterprise Envisioned Future will be assessed.

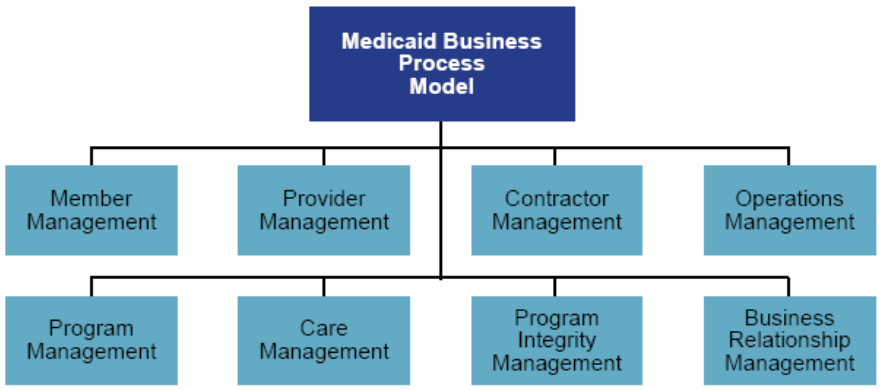
The Current Capability assessment revealed that while there has been progress in modernizing the way the Medicaid enterprise conducts its business processes, by and large there are still significant uncoordinated, manual processes proliferated among siloed entities who are delivering or administering a piece of the Indiana Medicaid program. ***Additionally, OMPP primarily provided the majority of input into this assessment with limited participation of other Indiana Medicaid Enterprise entities such as DMHA, DA, ISDH, DOH and DFR***. The assessment also revealed that many business processes are undocumented, and thus not necessarily repeatable in the long term.

As we learned and documented in other MITA Assessment deliverables, the Medicaid Enterprise lead by OMPP aspires to a higher purpose and capability. Next steps of this Assessment process, which include the identification, assessment and documentation of Target or "To Be" Capabilities, as well as the development of a high level strategic Transition and Implementation Plan will start to provide a roadmap of measureable action steps, initiatives and projects to move towards the transformed Envision Future.

6 Appendices

Appendix A – Indiana MITA Assessment Standard

The Indiana MITA Assessment Standard is based the Medicaid Information Technology Architecture (MITA) Framework 2.0 Business Architecture Business Capability Model (BCM). The Indiana MITA Assessment Standard was developed through consultation with the Indiana OMPP Business Leads to identify and map Indiana's Medicaid business processes to the MITA Framework 2.0 Business Process Model. All MITA Business Areas and Processes in the Framework 2.0 were identified as present in Indiana business model.



This Assessment Standards is a high-level depiction of only the Business Areas and Business Processes. The detailed listing of the Business Capabilities, Characteristics and Measures associated with each Business Process can be found in the MITA Assessment Scoring Notes Report as these are extensive descriptions of functionality needed for a particular level of maturity. The capability of a process changes from one maturity level to the next.

Business Area	Business Process
Member Management	
	Eligibility Determination – Determine Eligibility
	Enrollment – Disenroll Member
	Enrollment – Enroll Member
	Member Information Management – Inquire Member Eligibility
	Member Information Management – Manage Member Information
	Prospective and Current Member Support – Manage Applicant and Member Communication
	Prospective and Current Member Support – Manage Member Grievance and Appeal
	Prospective and Current Member Support – Perform Population and Member Outreach
Provider Management	
	Provider Enrollment – Disenroll Provider
	Provider Enrollment – Enroll Provider
	Provider Information Management – Inquire Provider Information
	Provider Information Management – Manage Provider Information
	Provider Support – Manage Provider Communication
	Provider Support – Manage Provider Grievance and Appeal
	Provider Support – Perform Provider Outreach
Contractor Management	
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – Award Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – Close-Out Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) – Manage Administrative Contract
	Contractor Information Management – Inquire Contractor Information
	Contractor Information Management – Manage Contractor Information

Business Area	Business Process
	Contractor Support – Manage Contactor Communication
	Contractor Support – Perform Potential Contractor Outreach
	Contractor Support – Support Contractor Grievance and Appeal
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – Award Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – Close-Out Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – Manage Health Services Contract
Operations Management	
	OM1 – Service Authorization – Authorize Referral
	OM1 – Service Authorization – Authorize Service
	OM1 – Service Authorization – Authorize Treatment Plan
	OM2 – Claims/Encounter Adjudication – Apply Claim Attachment
	OM2 – Claims/Encounter Adjudication – Apply Mass Adjustment
	OM2 – Claims/Encounter Adjudication – Audit Claim/Encounter
	OM2 – Claims/Encounter Adjudication – Edit Claim/Encounter
	OM2 – Claims/Encounter Adjudication – Price Claim/Value Encounter
	OM3 – Payment and Reporting – Prepare Coordination of Benefits (COB)
	OM3 – Payment and Reporting – Prepare Explanation of Benefits (EOB)
	OM3 – Payment and Reporting – Prepare Home and Community-Based Services (HCBS) Payment
	OM3 – Payment and Reporting – Prepare Premium EFT/Check
	OM3 – Payment and Reporting – Prepare Provider EFT/Check
	OM3 – Payment and Reporting – Prepare Remittance Advice/Encounter Report
	OM4 – Capitation and Premium Preparation – Prepare Capitation Premium Payment
	OM4 – Capitation and Premium Preparation – Prepare Health Insurance Premium Payment

Business Area	Business Process
	OM4 – Capitation and Premium Preparation – Prepare Medicare Premium Payment
	OM5 – Payment Information Management – Inquire Payment Status
	OM5 – Payment Information Management – Manage Payment Information
	OM6 – Member Payment Management – Calculate Spend-Down Amount
	OM6 – Member Payment Management – Prepare Member Premium Invoice
	OM7 – Cost Recoveries – Manage Drug Rebate
	OM7 – Cost Recoveries – Manage Estate Recovery
	OM7 – Cost Recoveries – Manage Recoupment
	OM7 – Cost Recoveries – Manage Settlement
	OM7 – Cost Recoveries – Manage TPL Recovery
Provider Management	
	Provider Enrollment – Disenroll Provider
	Provider Enrollment – Enroll Provider
	Provider Information Management – Inquire Provider Information
	Provider Information Management – Manage Provider Information
	Provider Support – Manage Provider Communication
	Provider Support – Manage Provider Grievance and Appeal
	Provider Support – Perform Provider Outreach
Program Management	
	Accounting – Manage 1099s
	Accounting – Perform Accounting Functions
	Benefit Administration – Designate Approved Services/Drug Formulary
	Benefit Administration – Develop and Maintain Benefit Package
	Benefit Administration – Manage Rate Setting
	Budget – Formulate Budget

Business Area	Business Process
	Budget – Manage Federal Financial Participation for MMIS
	Budget – Manage Federal Medical Assistance Percentages (F-MAP)
	Budget – Manage State Funds
	Program Administration – Develop Agency Goals and Initiatives
	Program Administration – Develop and Maintain Program Policy
	Program Administration – Maintain State Plan
	Program Information – Generate Financial & Program Analysis/Report
	Program Information – Maintain Benefit/Reference Information
	Program Information – Manage Program Information
	Program Quality Management – Develop and Manage Performance Measures and Reporting
	Program Quality Management – Monitor Performance and Business Activity
Care Management	
	Establish Case
	Manage Case
	Manage Medicaid Population Health
	Manage Registry
Program Integrity Management	
	Identify Candidate Case
	Manage Case
Business Relationship Management	
	Establish Business Relationship
	Manage Business Relationship
	Manage Business Relationship Communication
	Terminate Business Relationship

Appendix B – Indiana Current Assessment Scoring Notes Report

The Indiana Current Capabilities Assessment Summary Report provides the maturity level for each business process area and business process and reflects Maturity Level 1 for the Indiana Medicaid Enterprise as a whole. To achieve a maturity level score higher than Level 1, all measures for that process area must be affirmed or deemed to be present based on MITA definitions. The report identifies the highest maturity level completed at one hundred percent (100%) for each business process completed and the highest common maturity level for the business process area. The report also displays the average maturity level for the business process area.

The Indiana Current Assessment Scoring Report detail is attached by reference. The detailed report for each Business Area includes all Business Processes, Business Capabilities, assessment questions on each of the characteristics or qualities and notes across all the capability maturity levels and the scoring for each area. The reports are available in pdf format through the Indiana MITA Assessment Project information repository.

Appendix C – Technical Capability Assessment Resources

To conduct this portion of the MITA Assessment, 4TG relied heavily on the findings numerous recent assessments that provided more than sufficient documentation that no current Technical Capabilities for the Medicaid Enterprise exceed a Level 1. These findings were documented and reiterated across multiple studies, reports and recommendations, including but not limited to:

1. FSSA Evaluation Committee (Legislative Services Agency) August 24, 2005
   http://www.state.in.us/legislative/interim/committee/2005/committees/minutes/FSSA88O.pdf

2. Increasing Interoperability in Health Information Systems for Medicaid, Mental Health, and Substance Abuse Treatment, and Indiana – CMS – SAMHSA Health Information Collaboration (CMS and SAMHSA) January 24-25, 2007

3. Indiana Awards EDS New $209 Million Medicaid Contract (EDS), and FSSA and EDS Contract

4. Current FSSA Technology Environment (KSM Business Services, Inc.)
   http://www.in.gov/fssa/files/FSSA_IT_Summary.pdf

5. State of Indiana 2007 Information Technology Strategic Plan and Mid Year Reports, and Indiana 2008 State of the State IT (Indiana Technology Leadership Team)

6. FSSA Division of Technology Services Direction Alignment (January 7, 2008) and FSSA Technology Priorities (12.27.08)

7. Eligibility Modernization Project Documentation – FSSA 10 year $1.16 billion project with the IBM-led coalition including: Affiliated Computer Services, Inc., Alpha Rae Personnel Inc., Crowe Chizek and Company, Haverstick Consulting, Interactive Intelligence, Phoenix Data Corp., RCR Technology Group and Arbor Education & Training,

8. Enterprise Data Warehouse Solution Assessment and Roadmap (Moongate Technologies and digitalKnowledge)

9. OMPP Data Warehouse Assessment (Moongate Technologies).

Appendix D – Validation Session Participants

The following table represents all participants in the Current Capabilities survey effort, documentation collection and validation sessions.

1. Member Management (ME)	
Survey	Cindy Stamper – OMPP Business Lead
Validation Session	Cindy Stamper – OMPP
	Stephanie Baume – OMPP
	Sharon Reynolds – Maximus
	Nehru Motilal – OMPP
	Judy Mitchell – OMPP
2. Provider Management (PM)	
Survey	Mark Vonderheit – OMPP Business Lead
Validation Session	Mark Vonderheit OMPP
	Arnetta Jackson, DDRS
	May Rifka, EDS
	Sarah Edwards, OMPP
	Tracy Myszak, OMPP
3. Contractor Management (CO)	
Survey	Jina Hughes – OMPP Business Lead
Validation Session	Jina Hughes – OMPP
	Nathaniel (Nate) Arnold – OMPP
	Stephanie Baume – OMPP
	Jay Edmondson – DDRS
	Greg Stenger – DTS
4. Operations Management (OM)	
Survey	Sharon Page – OMPP Business Lead
Validation Session	Randy Miller – OMPP
	Amy DeYoung – DTS
	Sharon Page – OMPP
	Beth Linginfelter – EDS

	Carolyn Hatton – EDS
	Phyllis Salyers – OMPP
	Stephanie Baume – OMPP
	Renee Payor – OMPP
	Cynthia Adams – EDS
	Gary Tremblay – EDS
	Jim Martin – OMPP
	Nehru Motilal – OMPP
	Sharon Reynolds – Maximus
	Ginger Brophy
	Mike Starnick
5. PROGRAM MANAGEMENT (PG)	
Survey	Donna Wells – OMPP Business Lead
	Terri Willits – OMPP
Validation Session	Donna Wells – OMPP
	Randy Miller – OMPP
	Stephanie Baume – OMPP
	Mike Sharp – OMPP
	Medina Lee – OMPP
	Bridget McLaughlin – OMPP
	Terry Willts, – OMPP
	Kristine Ellerburch – OMPP
	Donna Kinnick – FSSA
6. CARE MANAGEMENT (CM)	
Survey	Stephanie Baume – OMPP Business Lead
	Katie Holeman-Ship – OMPP
Validation Session	Stephanie Baume – OMPP
	Katie Holeman Shipp – OMPP
7. PROGRAM INTEGRITY MANAGEMENT (PI)	
Survey	Catherine Snider – OMPP Business Lead
Validation Session	Stephanie Baume – OMPP
	Emily Martin – Health Care Excel
	Gwen Taylor – Health Care Excel
8. BUSINESS RELATIONSHIP MANAGEMENT (BR)	
Survey	Jina Hughes – OMPP Business Lead

Validation Session	Jina Hughes – OMPP
	Nathaniel (Nate) Arnold – OMPP
	Stephanie Baume – OMPP
	Jay Edmondson – DDRS
	Greg Stenger – DTS
	Lottie Hooyer – IDOA
	Paul Bowling – DMHA